AN INTRODUCTION TO CHILD GUIDANCE

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Preface

RECENT developments in education and child welfare have included a growing interest in the problems of the maladjusted child. The number of enquiries about their work received by the staff of a child guidance clinic suggested the need for a simple account of the organisation, working and possibilities of these clinics as a method of dealing with such problems. The present book is intended as an introduction to the subject for all those who are actively concerned with the problems of children and young people, whether as members of education or youth committees, as magistrates, probation officers, teachers, doctors or social workers. We hope that it will also be found useful by students intending to work in child guidance clinics, as well as by those studying education, social science, psychological medicine or pediatrics.

As the joint production of a psychiatrist, a psychologist and a psychiatric social worker, each with a somewhat different approach, the book is a reflection of the team-work essential to child guidance itself. We hope that this fact will excuse any apparent discontinuity resulting from the different authorship of succeeding chapters. Though we have worked together as a team and are in substantial agreement on the main issues, we have not hesitated to express our individual points of view, and these are not always identical with those of the other contributors. We do not wish to be held jointly responsible for every opinion expressed, and have therefore indicated the authorship of the chapters in the Table of Contents. Child guidance work is still at a stage which demands a certain amount of fluidity in organisation and experiment in method. It is not to be expected that other workers within the movement

will accept all the conclusions which we have drawn from our experience, but if some would have seen things differently, or given a different bias, this will not detract from the value of the book if it helps to stimulate interest and discussion.

The illustrative material used is drawn from various clinics in which we have worked, and we should like to express our thanks to the committees responsible for these clinics, to all those who have referred cases, and to the parents and children concerned; and to assure them that no case has been quoted in an identifiable form, and that all names used are fictitious. Our thanks are more particularly due to Sir John Stopford, F.R.S., Vice-Chancellor of the University of Manchester, and Mr. W. O. Lester Smith, Director of Education for Manchester, for reading the manuscript, to Miss S. Clement Brown for criticising Chapters Five, Seven and Twelve, and to Mr. L. J. F. Brimble, joint editor of *Nature*, for advice and help while editing the book.

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Introductory

PSYCHOLOGICAL principles and methods of work are notoriously difficult to formulate. They lack the precision of the other sciences, and they depend on fluid and changing human material, and of all groups of scientific people, psychologists are the most criticised for using terms that the layman does not understand. It would seem that this is not because they actually do use more jargon, but because everyone accepts now the terms 'atom' and 'electron', and if the uninitiated does not know what the 'atomic theory' is, he has stopped blaming the chemist or physicist and either sets to work to find out or accepts the idea that it is outside his scope. But no one feels quite like that about matters which concern himself on a more immediate and intimate basis; and the feeling arises when an incomprehensible flow of strange words is produced, that this is somehow getting at him, just as he used to feel in the nursery when the grown-ups lapsed into French and he knew they were talking about him. Consequently he resents this language and demands that people shall talk of him so that he can understand. On the other side of the picture, it does appear sometimes as if psychologists had taken refuge in high-sounding Greek or Latin derived words in order to hide a confusion of thought which they have been unable to unravel. They have sometimes forgotten the principle that that which is clearly conceived can be clearly expressed.

In the popular view, there is also another feeling about the use of strange and peculiar words. They savour of magic, they are linked with the sort of fear and mystery that the word 'abracadabra' brought to the child's mind. I once

had a child referred for pilfering, whose mother told me with pride, "I have told her you can see right inside her brain and know exactly what she is thinking, so it is no use telling you lies," and I have been many times introduced with more or less seriousness as "one of those people to whom you have to be very careful what you say, as they always see another meaning". Definitely there is still a feeling that the power apparently to see hidden thoughts and to understand unexpressed meanings implies magic, even though actually there is no more to it than for the hairdresser to produce golden hair with a fluid which looks like water or for the colour green to be produced by a mixture of blue and yellow pigments. All these things, so wonderful to the uninitiated, are only a question of 'knowing how to do it'. And here a word of warning: knowing how to do it is just as important in psychological as in chemical work. A dangerous explosion may be produced by the ignorant playing in a chemical laboratory, a fatal electric shock may be given or received in a physical one; equally dangerous is the practice of playing at psychology, only the material here which is liable to be destroyed or damaged is human minds rather than bodies. Of the practice of all sciences it is true that 'a little learning is a dangerous thing', of this one no less than the others, and just as we have learned of medicine that certain drugs must be on the 'poison list' and only obtainable at the hands of the expert, so should this be true of psychological treatment.

If this book succeeds in the aim of its authors it will have conveyed to the reader not only some kind of answer to the questions many people are asking, but also some understanding of the delicacy of human minds, and a realisation of when to leave the handling of them to those who have undertaken training for this work. No one suggests that everyone with a common cold should go to a doctor — patients cure themselves or their friends produce remedies of simple and

harmless nature; but equally no one expects this kind of handling when the common cold has become pneumonia — then the expert is called in. Minds are even more delicate and precise machines than bodies, and while it would be ridiculous to suggest that we should be always thinking of them in this way and wrapping them in cotton-wool, their adjustment demands a knowledge of normal and pathological working which it is impossible for everyone to acquire.

The idea of applying psychological methods to the handling of difficult children originated in the United States where the first clinics were started as a result of Healey's interest in, and desire to work with, delinquents from the juvenile court. His first attempt was the Chicago Juvenile Psychopathic Clinic, which was founded in 1909, and was followed in 1915 by the Judge Baker Foundation in Boston. After this a series of clinics followed, and the necessity was recognised early of having somebody attached to the clinic who could work with homes and parents. The work of the early clinics was mainly diagnostic and advisory; but out of it there were arising ideas which put the whole movement on a broader basis, both as to its scope and function.

It soon became clear that difficult children existed outside the juvenile court, and that problems which could be tackled in this earlier stage gave a much better promise of success; and it also became evident that this new medical work was incomplete unless it could carry out or advise treatment to deal with the ills it had diagnosed. Thus the idea of a clinic for the handling of emotional disorders in childhood, whether evinced by abnormal or anti-social behaviour or in other ways, developed from those earlier and more limited efforts.

Further, the need for training and education became evident, and demonstration clinics for these purposes were next started. These were originally the work of the National Committee of Mental Hygiene acting on behalf of the Commonwealth Fund, and the first report recommending the establishment of such clinics was issued in 1922, embodying

environment — children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behaviour, or inability to cope with social or scholastic expectations." The essence of this approach is that behaviour is studied objectively, as nearly as possible without prejudice, in the hope of discovering the causes, usually multiple, which produce it, and that an effort is made to modify it by eradicating or abating the causes rather than by precept or the imposition of authority.

The foregoing paragraph makes it clear that the work of a clinic of this kind is concerned with "unsatisfied inner needs", emotional needs, and not primarily with either physical or intellectual difficulties. These may nevertheless come into the picture, where they have been the main cause or a contributory one to the failure of emotional adaptation. Personal happiness can only be achieved and full service to the community can only be rendered if an individual is an integrated personality. Perfection on all sides we can never hope to achieve. Integration includes the harmonious working together of all parts of the person, who must accept such limitations as may be imposed on him by defects of structure or functional poverty, and use to the full all the powers that are available to him. Emotional difficulties have, up to very recent times, been regarded as something different from other incapacities; we accept physical lameness or a lack of ability to do mathematics in others with philosophic calm, admitting them as 'acts of God' by which we intend that they are outside the control of the individual concerned; but when we come to irritability, fear of the dark, compulsive hand-washing or apparently purposeless theft or wanton destructiveness, we are inclined to regard these things as matters which can and should be controlled, to tell the child or adult to 'use his will-power' or in popular parlance 'pull his socks up', and to forget that these things are as much ailments of the mind as physical lameness is an ailment of the body and as little

amenable to the use of will-power. To dismiss such symptoms as awkwardness or naughtiness is to misunderstand the whole situation; to treat as a matter for a joke or for pride that a child is 'highly strung' or 'sensitive' or 'shy' is equivalent to taking a pride in the fact that he has constant colds or repeated 'growing pains'. It is true that there are parents who do enjoy having frail children whether the frailty be physical or emotional, and this is difficult to cope with; but it is usually commoner in the emotional sphere, or at any rate more overt.

In recent years, scientific periodicals and even newspapers have all borne testimony to the amount of wasted life which is the result of 'functional' illness, that is illness produced by mental causes whether its symptoms actually be on a mental or physical level. Accident proneness, absenteeism in industry, and broken marriages, are evidence of this sort of ill-health. Social offenders in jail, carping critics and those who never fulfil the promise of their intellectual endowment, or who go about perpetually unhappy and dissatisfied, are also crying witness to the failure of our present methods of handling the developing personalities committed to our care. There will, of course, always be breakdowns; but we are living in times when there is talk from many quarters of reconstruction and progress. We are always fighting for freedom in some way or other, but we must first be free to accept freedom, free within ourselves without internal conflict and strife. At present we are apt to bring up children as if we were so many dictators, treating every free expression of opinion as a criticism of or 'cheek' towards ourselves, and we destroy initiative before the child is adolescent and then wonder why so few leaders are among us; or, on the other hand, we give a licence which makes it impossible for the child to be free to choose among others, since he has never had to share, but has been able always to exercise his individual rights. The truth of happy living lies between these: we are individuals in society.

Every child, as he grows though childhood and adolescence to maturity, must learn first to assert himself against society, and second to accept society against himself. In infancy his physical and economic dependence and his lack of experience combine to induce him to conform to the dictates of others against his own desires, since only by his contact with them can he feel secure. As he develops and his experience grows, he realises that there may be diverging views, and he begins tentatively to express his own. At this stage it is just as important that he should have freedom to do this as that he should have freedom to walk, and we should help and encourage him, neither holding his inexperience up to ridicule nor filling him with guilt because we feel our power threatened by his first steps in independence, and therefore treat them as moral lapses. Thus he can learn gradually to tolerate the insecurity of standing alone — an individual. Along with this lesson must come its other half, that always we live in a society which expects us to adapt our individuality to its welfare.

Elsewhere we discuss how this happens among children free to play together. Suffice it here to say that the failure to be able to do this comes from insecurity as an individual, an insecurity which must be compensated for by an over-assertion of the rights of the individual and which shows itself in an incapacity to fit into society while retaining that individuality. Growing up emotionally is a slow process, and our educational methods must be adapted to the stage which the child has reached. It is as useless to push freedom on a child whose personality is as yet insufficiently developed to give up even some of the security of dependence as it is harmful to refuse it when he is ready. Early flights may be unsteady, they may even result in accident; it is for us to see that accident is not allowed to be disaster, but not to clip the newly grown wings.

In child guidance work the team method has been developed to deal with the different aspects from which diffi-

culties may have arisen. In the original scheme the psychiatrist's share of this work was with the child himself, the social worker's with the environment, whether parent, school, or social agency of one or another type. At this stage the educational psychologist was not included. As the work has developed this third member of the team has been incorporated at first in order to study and test the patient's intellectual capacity, since obviously we must know this when assessing the causes of his breakdown; and secondly, to help him over any actual educational backwardness where this exists and is remediable. Broadly speaking, this division of work is still the one most usually found in clinics; but there are many variations on it, depending both on the individual training and experience of the workers, their special aptitudes and the time available.

Fluidity is very important in work as yet so tentative and immature; like the children we treat, we need room to experiment. Moreover the question of training and the difficulty of getting trained personnel is one which contributes its own share to the need for adaptability. Necessarily, there must be some co-ordinating figure in the team, and it is commonly the psychiatrist who stands in this position. This is partly because, given equal circumstances, his training is wider and covers more aspects of the case than either of the other two workers, but also because the world with which we deal, the world of parents, teachers, magistrates and so on, will often accept the authority of the doctor where they might refuse that of one whom they regard as a layman like themselves.

If this is to be so, it is essential that psychiatrists should be adequately trained to their work, which means that they must first be trained as physicians, then as psychiatrists, with a knowledge of both psychotic and neurotic disorders, and finally in the special work of the handling of emotional disorders of childhood. Apart from actual formal training, a real knowledge of children, healthy and ill, and of the

circumstances of their lives is of importance.

The training of the psychologist involves equally a knowledge of children, together with a training in the scientific testing of intelligence and some experience of teaching methods specially adapted for educational difficulties. Such training should always include a degree in psychology and some actual experience of teaching, together with special training and experience in a child guidance clinic.

The psychiatric social worker, whose main function is to work with the environment, needs first an adequate training in and knowledge of social administration, both from its legal and personal aspects, and such training should and does carry with it practical experience in different branches of general social work. Many people who work in this field have actually had experience in other branches of social work — care committees, probation work, hospital almoning and so on. All this is valuable, but since her main work is psychological the psychiatric social worker needs further special training in Mental Health.

Yet, in describing all this, we have only really considered a part of the problem, albeit an absolutely necessary part. But another and also most essential qualification must be a real love for children, and not just an academic scientific interest in their problems. We have to remember that while in dealing with an adult suffering from neurotic disorders, we have the co-operation of at least part of himself — the awareness of his adult reason that the doctor is there to help him and is trained to do so ; but with the child this is not so, first because he comes, willy-nilly, by command of his parents, and secondly, because in any event this side of his personality is as yet either only partially or not at all developed. Consequently while the adult patient, whatever his unconscious resistances, has a conscious intention to get better, and an awareness that something is wrong, with the child the position is different. To him the psychiatrist is only another adult, just like those in whom he has already lost

faith, or to whom he is clinging blindly because he is terrified at the prospect of losing the security of his infantile hold. There is no more reason why he should trust the doctor than his mother or father, and at least, since they are on the spot, they are the more likely to be dangerous, and therefore must be placated. Even the adult patient when he first begins to discuss his private thoughts and feelings about those near to him, finds himself afraid; and often tries to escape by saying that loyalty forbids him to do so. How much more is this true of the child, who simply dare not feel himself separated from the protection of his parents, and therefore cannot talk of his anger and hate?

To start with, then, we have to convince the child, in a way that is unnecessary with adults, that he can trust us, that we are there to understand and to respect his confidence; and to do this we must go part way, sometimes all the way, to meet him. Analytic methods with adults include an approach which is detached, which views problems objectively and which waits for the patient to unfold his own thoughts; but even with adults it is often necessary, especially at first, to modify this attitude, and go some way to encourage and draw out the patient by a sympathetic understanding. With children this is much truer; in the nature of the case, the child expects the first advance from us, and while we may observe and analyse and note our estimate of his problem, we must in dealing with him be more human and less scientific.

Perhaps these remarks may have seemed a digression from the subject of training; but in reality it is not so, for the burden of them is that the first necessity to anyone undertaking this work is a real love of children. It is just as true that no one will make a good member of a child guidance team, whatever his intellectual endowment, whatever his scientific knowledge, whatever his theoretical background, without this, as it is true that no one ever makes a good teacher without the same love. In this rela-

tionship the grown-up can be with the child at once grown-up and child. Every child knows intuitively when the grown-up is 'playing down' to him, and when on the other hand some part of him is really in the play situation with him, feeling with him. It is only when the understanding is real in this way that full confidence and a real relationship from which development can begin are established.

Even this, while we find it to be the most fundamental need of all, is not alone sufficient. Love of children of a kind, even a certain insight into their problems, is often present in neurotic persons; it is there because those persons are themselves still in the same emotional phase as the children whom they understand. They are children alongside the child, and the child enjoys them. But since they are neurotic, they are not also 'grown-ups' to the child; they can share in his difficulties, but they cannot help him to deal with them, they cannot enable him to grow beyond them, since that is something which they themselves have not achieved. To be able to do this, it is important that they should first find out what it is that is holding up their own development and grow beyond the childish without losing the child-like. Self-knowledge is essential to the therapist for this reason, and such self-knowledge can only be obtained through a personal analysis. This is true of all would-be therapists, both the immature and those who do not consider themselves as neurotic and are accepted by others as normal people.

No one would dream of setting up as a surgeon or as a dentist who had never seen an operation or filled a tooth. First operations are performed on a cadaver or under the watchful eye of an expert surgeon. But this particular operation is one which cannot be watched, except when it is performed on oneself. Thus several things are achieved by a personal analysis: first and foremost, a knowledge of the hidden processes of one's own mind, and awareness of how different things may be within from what they appear, how vanity may masquerade as shyness, and self-assurance conceal

a sense of insecurity, how cruelty and violence may cover a great fear of weakness, and over-protectiveness and anxiety be the result of a deep-seated hatred. An adult patient recently put it in a nutshell, saying, " I hate to think I'm not the good little girl I'm supposed to be ". Secondly, a knowledge is gained of the science and art by which these hidden facts are revealed and a real acceptance of the principles of psychology to the truth of which they have been witness; and finally, an awareness of the fact that however 'normal' we may have appeared, we are in fact 'as other men are', an awareness which should make us less resentful and more objective in our judgments and tolerant in our outlook. In particular, in work with children we should be able to see the difficulties of both parent and child and to help both to a happier adjustment.

This point brings us to another and very important one in the team work. We are often faced, in fact, with two patients in the child guidance clinic — the parent and the child, sometimes with the other parent who never appears, or the teacher, as a third. One very important principle in all psychological work is that it is unsatisfactory for one person to treat two members of a family at the same time. Inevitably there is loss of confidence, each feels that the other is favoured, and so in a situation where it is common to find at least two people involved the team method enables us to have separate workers dealing with both simultaneously. Certainly this sometimes brings about a failure in the treatment. Recently we had a case where mother and son came together. In the course of talking to the social worker the mother made revelations about her husband's behaviour both to herself and to the boy, which frightened her so much that on the next occasion she sent him alone. Afterwards, our efforts to re-establish contact with her merely ended in the cessation of his attendance also.

Nevertheless, in many cases, it is just this combined attendance that really secures improvement, and for this

reason it is of the first importance that both the therapist dealing with the child and the social worker dealing with the adult environment should themselves have this personal and inside knowledge of psycho-pathology. This does not mean that the personnel of a child guidance clinic undertakes the analysis of adults; it would be impossible and probably undesirable that this should be so. Analysis is often a highly disturbing process, and it would often be bad for a child to be going home with his parent when the latter was occupied and disturbed by such a session. Where the parent needs this and cannot be adjusted without it, it should for choice be carried out elsewhere; but many problems can be adjusted, or at any rate improved, without such a radical method by a person who can use her knowledge of the workings of the mind, and interpret something of the reactions she sees going on around her.

With a psychologist who is doing only the actual work of testing, the position is a little different. Here we have an objective scientific method, less dependent on the personality of the tester, and less concerned with the emotional state of either child or examiner. Thus formal training is of relatively greater importance, and personal adjustment relatively less so. Even here this is only very partially true; one has seen people testing whose own obvious anxiety clearly has its effect on the child, and others whose cold, scientific detachment was like a polar atmosphere, freezing the child into a state of inhibition. Further, the psychologist who most contributes to the solution of the problem is the one who is awake to many things in the child's responses beyond his actual answers, and can give a fuller picture than just a bare assessment of his immediate intellectual response in terms of an intelligence quotient, and to do this the same love of children and the same personal adjustment and awareness of mental mechanisms are necessary.

We have said earlier, however, that we regard this work not just as therapeutic, but also as preventive, educational

and social, and we turn now to these aspects of it. Education, we repeat, is, in our conception, the achievement of maturity, and maturity a matter of harmonious integration of all parts of the personality. A century and a half ago the conception of education for the wealthy was for boys the achievement of a capacity to use a sword or to recite Latin, and for a girl to do fine needlework. Knowledge of the sciences was considered something vulgar, and to be able to read not a necessity for a refined young woman. Among the poorer classes of society the value of children was estimated in terms of wage-producing, and the idea of developing a child's natural intellectual capacities never appeared in the picture. In the first three quarters of the nineteenth century this aspect of things changed, and the development of the intellectual faculties of both sexes became recognised as a matter of sufficient importance to be considered seriously and to become the responsibility of the State; but at this stage it occurred only to an occasional thinker that the best use of the intellectual faculties could only be achieved where there was physical competence, and that rickety children, badly fed and housed, were in no fit condition to use their capacities to the best advantage. When this gradually became commonly accepted, child welfare and school medical services grew up, and it became possible to insist that parents should not only send their children to school, but also that they must keep them adequately clothed and clean. Physical needs and ailments were provided for by school feeding and school clinics, and regular supervision of the child's physical development became another part of the State's responsibility.

It was the waste of time and energy, the obvious misfits and chronic invalidism that became so obvious in the War of 1914–18 which forced attention to the fact that we are still only part of the way in our education system to providing for the necessary all-round development, and this last facet, satisfactory emotional development, is still slow in receiving recognition.

It is still possible for the head of a school to say of a child with a lame foot, hysterical in origin: "Does it matter, when her school work is so good?", and still possible for a responsible authority to feel that a child who is vomiting in order to get away from school because she is afraid of her teacher is 'quite normal', and that the teacher is just 'bad', and to be unable to see that because the last statement may be true it does not follow that the first is. To run away in such a case may be normal; to have to be ill in order to escape is definitely not so. It is also still common to find parents and teachers having regard only to their own point of view in helping children to choose a career. How often we hear the phrase "I shall put him or her to so and so", or in school that "It is a waste of good brains" that she should nurse or do domestic science.

The idea of social advance or, on the other hand, immediate wage-earning are two goals at which opposing types of parents aim, and the credit to the school of academic success and therefore interest centred mainly on those likely to achieve it, is still the great curse of our educational system. Each of these is concerned primarily with getting something from the child, the parent either wanting to obtain social satisfaction, or desiring the relief of financial difficulty, the teacher believing that intellectual successes are the only proof of his own work. Neither, where these ideas prevail, is considering the ultimate welfare of the developing personality. It must not, of course, be thought that we consider that all parents or all teachers behave in this way; there are very many and an increasing number who see education differently; but the trend of our civilisation has been to set a premium on success whether financial, social or intellectual.

On psychological principles, the education of a child should aim at training him to express himself in his life, to choose his career as nearly as possible to fit his own natural bents and tastes, without regard to the father's achievement

of his own frustrated desires through his son, and without any sense of duty to a school which would force him because he has an intelligence quotient of 130 to go to a university when his desire is to go to sea.

This is not an easy thing. It is much easier to teach than to enable people to learn; it is much easier to command than to lead; and it is still more difficult to lead from behind. Education of this kind has to stop laying the stress that is at present put on formal learning and actual acquiring of information; it has to realise that, after all, the very large proportion of the specific knowledge we acquire at school and at university is lost to us very shortly after. How often do we, even those of us engaged in professional work, look back at examination papers which once, quite recently, we would have found easy, to realise that we could not touch them now!

So much for the negative, but we need a positive side. We need to know how to live. Schools could be much more closely related both to homes and to the outside world than they are. This relationship between school and business, school and the society of the State could be much closer, and the transition from one to the other could be much more gradual. On both sides adjustments have to be made, teachers need to learn that the intellectual professions are not, or should not be, divorced from, or superior to, business and trade; and business has no need to regard the teachers as unpractical and unrelated to reality.

The raising of the school leaving age may sound an ideal scheme, yet many children have neither the desire nor the intellectual capacity to profit by further education of the present type, and unless a great deal is done to correlate and bring together education and vocation, it would seem likely that the problems presenting themselves between fifteen and twenty will shortly appear instead between twenty and twenty-five. Children do not 'grow up', do not accept responsibility, do not become independent at home or school largely

because they are not allowed to do so, parents are not willing to tolerate them on an equal level, and teachers need, because of their own interests, to be reassured of the paramount importance of intellectual success and pursuits.

Many educationists, in high government and administrative office, in the universities and in the rank and file of the teaching profession itself, are at present urgently considering this problem, and there is great hope that there may evolve a new view of education along with a new view of life and that the core of this will be the idea of helping the child to learn the value of independence and to accept the necessity of responsibility; so only can we get some measure of true democracy. Psychologically speaking, this can only be achieved by bringing discipline into relation with reality instead of with power, so that external discipline can gradually make a transition to discipline from within, and by unfolding to the child as he develops a series of purposes in which he has interest and for which he has capacity, thus awakening in him the desire to go forward and achieve his independence. One of the difficulties, especially in young children, is the limitation of both their vision and their capacity, but if we watch their play, and observe their struggle in phantasy with problems of reality, we may get many hints which will contribute to the solution of educational problems.

Chapter Two

Establishing and Organising a Child Guidance Clinic

In the initial establishment of a child guidance service two separate aims must be kept in view. First, the clinic needs the best facilities for dealing with the diagnosis and treatment of the children referred to it. Secondly, the clinic should be organised as a potential educational service in the psychological aspects of children's development. The aim should be to have this service available for all categories of people connected with the education and upbringing of children.

The fulfilment of these two different functions requires that different aspects in the staffing, housing and equipment of the clinic should be considered. This chapter describes only the minimum requirements of a clinic designed for diagnostic and therapeutic work. The second function of the clinic as an educational unit raises wider problems which must be dealt with in different ways by different administrations; these will be discussed in the chapter on future developments (Chapter Fourteen).

Before any clinic can be established, a degree of understanding of the aims and methods of child guidance must be achieved in the members of the lay committees of the administrative body under which it is run. It is these people who must vote the money in the beginning and who control the finance of the clinic from year to year, and who can therefore encourage or cripple its growth.

A survey of the present child guidance service shows that clinics can be run as out-patients' departments of a general, children's or mental hospital, as a branch of the school medical service under the local education or

public health authority, as a training unit attached to a university or training college, or as a venture financed by voluntary subscription. These different types of clinics have their own special problems in organisation and administration; but all depend for their smooth working and development on the attitude of the administrative body behind them. The hospital boards, the education and public health committees, the boards of governors of training colleges, and the voluntary clinics are all composed of members who are in the main lay citizens. These are drawn from all strata of society, varying individually in degree of intelligence and knowledge, differing in matters of politics and religion, and often holding widely divergent but fiercely personal views on the upbringing of children. It is essential that these people should be sufficiently interested in the work of the clinic to allocate money to it and to take responsibility for its work. This interest is usually aroused in the first instance by publicity being given to the needs of certain individual children who are in real difficulties and for whom no provision is being made. For this interest to be effective in the establishment of a child guidance service there must be available someone with a sound knowledge of child guidance who can describe its aims and methods and show how a clinic could help not only the particular children in question, but how it could also act as a preventive service.

Such a person will need something more than knowledge of child guidance, he must also have a breadth of view and experience of people sufficient to overcome individual prejudices and to seize the opportunities of propaganda as they arise. In doing this he must remember that the progress of a committee in establishing a child guidance service is partly determined by its slowest members. There are frequently members of any lay committee who will oppose a movement simply on the ground that they do not understand it. Such opposition has [illegible] nuisance value to any

rapid progress. It is the education of these members that needs skill and patience and the fruits of wide experience.

In fact a study of the child guidance movement in Great Britain shows that the original demand has been of local origin, organised by people on the spot with knowledge of the needs and the way they can be fulfilled. Later in some cases assistance in the establishment of the clinic has been given by the Child Guidance Council in the form of loan services of trained workers for an initial period. Local stimulus has come from magistrates faced with difficulties of assessment of the children coming before them in the juvenile court, from doctors needing help in understanding the mental element in physical disease, from directors of education recognising the problems of their teachers faced with the difficulties of individual children in their schools, or from lay citizens who have grasped the significance of the needs which the child guidance clinic is there to fulfil. These people have been responsible for bringing the need for clinics to public notice.

The choice of administrative body under whom the clinic is to run will depend largely on the people who have been the moving spirits in recognising the need and formulating the demand. When these are magistrates or teachers it is usual for pressure to be brought to bear on the local education authority, when doctors then the clinic is more likely to be established as a part of the hospital service.

The organisation of any clinic from the beginning provides certain main problems to be faced. These fall under the headings of finance, the securing of properly trained personnel already described in the Introduction and the provision of adequate premises and equipment.

The financial problems of clinics attached to voluntary hospitals are usually more acute than with those attached to local authorities. This is one of the reasons why there are considerably fewer hospital clinics. A local authority clinic, usually run as a branch of the school medical service, ranks

for 50 per cent Board of Education grant, the other 50 per cent of the expenses being found by the local authority. The voluntary hospital clinic depends on a grant from the general hospital funds. These are usually inadequate to supply the needs of all the branches of medicine and to satisfy the conflicting demands of all the departments concerned. The child guidance clinic shows up poorly in sheer weight of numbers compared with the other out-patient clinics, and the income from patients' payments is therefore relatively low and the overhead costs per patient correspondingly high. This makes propaganda within the hospital administration difficult.

It would be a serious loss, however, if the financial difficulties involved resulted in the discontinuance of child guidance clinics attached to the out-patient departments of hospitals. The further establishment of these, in addition to local education authority clinics, is of the utmost importance.

A study of clinic records shows that hospital clinics, as would be expected, see a high proportion of cases with associated physical disturbance. There is a weight of evidence to show that these cases, if there were not a child guidance clinic attached to the hospital, would in all probability continue to be treated on their purely physical symptoms by purely physical means. Further, the reference of cases by doctors within the hospital, and the reporting back to them, and to the general practitioner concerned, on the psychological aspects of the case, provides an educational service within the medical profession similar to that given to teachers referring cases from schools. In addition, the hospital clinic gives the personnel working in it opportunities for a more detailed study of the relationship between physical and mental illness in children than is usually possible in other clinics. Attendance figures show too the real value of the hospital clinic to the parents, who come regularly of their own free will and seldom break their appointments.

Related to the problem of finance is the provision of adequate premises for the clinic, which usually proves a greater difficulty to the hospital than to the local education authority. Most authorities have control of a large amount of property, and are not limited by the four walls of a building as is the hospital. It is unusual too that a hospital can give to the clinic the sole use of all the rooms required, and often the rooms used are more suitable for physical therapy than for child guidance.

The minimum requirements for the premises of a clinic unit is four to six rooms—the psychiatrist, the psychologist and the social worker each require one, and further rooms are needed for parents waiting and for the office. Also if possible a large play room is a welcome addition. Every effort should be made to decorate these rooms in bright, cheerful colours and to make them inviting and friendly. It is an obvious convenience for parents and children if the clinic is centrally situated in a position easily accessible by public transport services. At the same time a house with a good garden has very marked advantages, and as this is usually not available in the centre of a town, the rival claims of accessibility and space have to be considered.

For purposes of economy, local education authority clinics are sometimes housed in empty rooms of a school. This has very grave drawbacks in that the school building tends to suggest to the child authority and restraint, ideas which are foreign to child guidance, and which mean an added barrier to be broken down before the true child guidance approach to the child's problems can be achieved. In no case should a clinic be attached to a school for mentally defective children, as the clinic then inevitably starts with a severe handicap in the minds of parents, and often teachers. Further, the use of the same premises as a special school results in an added referral of children of low intelligence and a consequent pushing out of the problem children of normal or super-normal intelligence. There are similar drawbacks to having

a clinic attached to the out-patients department of a mental hospital. Parents have an initial bias against it, and the children themselves may have a stigma attached to them through its associations.

Sometimes the child guidance clinic of a local authority may be housed in the precincts of the school medical clinic. This has both advantages and drawbacks. It is convenient to have medical records readily available, and special physical examinations can more easily be arranged. Further, in special cases the combination of a particular form of physical therapy with the child guidance treatment is made possible. For example, a debilitated enuretic needing child guidance may benefit from simultaneous sunlight treatment or a timid inhibited child may be usefully treated in the remedial gymnasium. On the other hand, the school medical clinic sometimes means to the child dental extractions or inoculations of which he may previously have been afraid; in such cases, before starting treatment the prejudice against coming has first to be broken down. Similar fears are frequently found in the hospital clinics, children having previously attended for some form of treatment that they feared.

The aim of most clinic personnel is to secure for their premises a roomy house with a garden where the atmosphere is homely and friendly and they have room to expand. Children in such a building can more easily relax, and when they realise that they can rely on ease and understanding, come freely and with joy.

The necessary equipment for the clinic is not elaborate. Apart from the usual requirements for a simple medical examination and some intelligence testing material, it consists mainly of normal, comfortable and strong furniture and an abundance of play material. An ideally equipped clinic has a deep sand tray and running water in every room used for therapy, one room at least with material for physical play, such as climbing, swinging, sliding, and an adequate supply of simple toys, dolls, beds, bricks, paints, 'Plasticine',

wherever children are seen. In choosing play equipment it is well to remember that it must stand up often to rough and even fierce handling, and that it must give as much stimulation as possible to the child's phantasy play. For this, toys representing all the common objects of everyday life are invaluable. In choosing furniture the importance of strength and comfort should be the foremost consideration. A minimum demand for comfort should be two easy-chairs in each room so that both the child or parent and the clinic worker can be at ease during the interview. In addition to a normal-height desk or table there should be low chairs and tables for small children, and one or two small rugs so that the floor can be used comfortably for play. It is unfortunate that money for the comforts of a clinic, which are so essential in obtaining the necessary easy atmosphere, has often to be dragged out of a committee when they would willingly spend far larger amounts on steel cabinets and testing material. It is difficult for people not acquainted with psychological treatment to understand that ease and comfort are as essential in a clinic of this type as is elaborate and expensive apparatus in a dental clinic or X-ray department.

The type of testing material required depends partly on the preferences of the psychologist. It consists usually of the current revision of the Binet Scale in duplicate forms, some performance tests and the Merrill-Palmer material for very young children. A good supply of test material, including accessories such as a stop-watch and requisite books, should not cost more than £50, and bare minimum could be obtained for considerably less.

Steel filing cabinets are the most convenient method of keeping case records, as the records often contain highly confidential material and it is essential that they should be kept adequately locked up.

An essential part of the clinic equipment is the forms which are used for recording the information about the cases. These are of no standard pattern, as different clinic

teams work in different ways; but it is worth while to give them detailed consideration at the outset and to revise them from time to time as required. There is usually one case-history form which is designed to include all the present relevant details about the child and his family, details of his early development and physical history, and a detailed account of his present problem and its origin so far as known. This form is as a rule filled in partly by the psychiatrist and partly by the social worker. There is a further form required for the findings of the psychologist from the intelligence test, and one which is designed to be sent to the child's school for the teacher's report. Combined with this case-history there is space for a summary of the case. This includes the diagnosis made from the available information from outside sources and from the clinic interviews, recommendations for treatment and a prognosis of the cases' future progress. There is also space left for closure notes on the results of treatment and for the findings of a follow-up visit at a later date. In addition to these case-record forms, clinics usually use diary sheets in each case, recording all the interviews, visits and correspondence in connection with it. Such diary sheets show at a glance the work that has been done, and are useful in compiling the report of the clinic's work which is usually made annually.

The task of the administrative body under which a child guidance clinic functions is not however completed when the clinic is staffed, housed and equipped. On the administrative body depends to a very great extent the scope of the work which the clinic is able to achieve. The establishment of any new specialist service usually takes away from other departments work which they have done, and inevitably the full functioning of a new service will depend largely on the co-operation of these departments both in handing over suitable cases and in providing all the available information on the cases. In child guidance work the difficulties in connection with individual children with which the clinic is

there to deal, have previously been dealt with often differently by other personnel. For example, the investigation of reasons for children running away from school have been entirely the province of the school attendance department. The officers of this department will continue to deal with a large percentage of individual cases which do not come within the scope of the clinic; but in this work they can be helped and interested by a knowledge of the methods and work of the child guidance team. They have therefore something to gain from the establishment of the service as well as something to contribute to it.

Within the administrative side of an education authority it is usually only the staff of the school attendance department who have a real experience of the individual child, and it is they, for example, who are responsible for the home surroundings reports on children coming before the juvenile court. This department is in possession of information about families stretching over the whole of the time the children have been at school. School attendance officers have a proprietary interest in the family and like to talk about them and to learn of any way in which they can be of assistance. They would benefit from knowledge of child guidance work and welcome discussion about it, especially when related to cases they know.

Similarly with court cases, real co-operation with the probation officers is helpful and educative to both parties. In treating children who are actually on probation, discussions with the probation officer concerned are obviously of particular value.

These problems concerning the position of a clinic within an administrative scheme differ widely according to the type of clinic, and are dealt with very differently by individual hospital and education authorities. Co-operation within the hospital where a clinic is an out-patient department often proves more difficult. The doctors concerned who

have dealt with the case previously are usually busy and handling too great a number of cases to appreciate much detail of one. It is seldom possible to see the referring doctor for any discussion on individual cases, and the only contact made is through the written report.

In any written report account must be taken of the interests of the recipient, thus the bias and terminology may need to be different for a doctor, a teacher and a magistrate. The value of the written reports depends also on its prompt circulation to the different people concerned with the case. The administrative body can facilitate this by the provision of adequate clerical help, and also by either allowing reports to go direct from the clinic, or by themselves being responsible for despatching reports to whoever is concerned. It is not uncommon to find that reports sent to directors of education and school medical officers are neatly filed away without ever being shown to the actual person referring or dealing with the child in question.

This brief outline of the administration of child guidance clinics is enough to indicate the degree of dependence of the child guidance movement on the administrative body under which it is run and on whose understanding it depends for its future development.

Chapter Three

Types and Sources of Cases

SOURCES OF CASES

ALL directors of child guidance clinics are faced from time to time with the question: Where do your cases come from and with what sort of problems do you deal?

Naturally, the answer depends to some degree on the freedom of the clinic to accept cases. The voluntary clinic is limited only by its case-load capacity and its financial state, but there are rapidly growing up clinics run under the auspices of the local public health or education authority, and in some of these the acceptance of cases is limited to those actually referred by the authority. This seems a pity. Many parents might come quietly to the clinic on their own initiative, where they would not run the risk of having the child's behaviour detailed at school or to the education office, since it might later jeopardise his chances of a place in a secondary school or a job. It is not inferred that this would really happen, but that the parents' fears must be taken into account. Occasionally the parents even wish to keep the matter from the school, and this is more difficult, since attendance in school hours is often necessary. Nevertheless, if it is possible to obtain an initial interview, one may be able to help them understand that their fears are groundless.

Frequently also parents themselves are involved in, or feel guilty about, the child's problem, and have no wish to have their family affairs paraded in public. That this is true is made clear by the fact that one of the complaints from parents and one of the reasons sometimes given by them for unwillingness to continue attendance after contact has been made is that "you are asked too many questions there"

However carefully intimate questions are asked this sometimes happens; and, given reasonable care and a clear understanding of the confidential nature of the interview, the amount of antagonism aroused is a rough gauge of the amount of guilt or anxiety which the parent feels.

The parent who is consciously aware that her desire not to have a child, or to have had one of the opposite sex, may have contributed something to the child's difficulties, the step-parent who understands that he or she may be a difficulty even though "I have done my best for him, but of course, he hasn't had a mother's love", or the one who realises that drink, or a violent temper or quarrelling or any other element of disharmony, may adversely affect a child's development is much easier to deal with than the one who only carries this knowledge in the unconscious mind and resents any attempt to lift it to the realm of reality.

Direct contact with schools and courts is also of first importance. We have occasionally met teachers who have expressed the feeling that to refer a child for bad behaviour is a reflection on the discipline of the school; and they struggle along with their problem hoping to avert the necessity, not realising that they are thereby sowing the seeds of later disaster. It does not follow that all bad behaviour in school should be referred to a child guidance clinic. Far from it, because much so-called bad behaviour is perfectly normal and natural, and often the far more serious problem is the over-good child; but bad behaviour which is purposeless and obviously pathological, or which reflects a sudden change or is out of keeping with the child's general character and background, these are commonly matters needing an outside and informed opinion. Perhaps if the general public were less wont to say glibly that the school is responsible for a child's character development, and more apt to remember the axiom of Ignatius Loyola: "Give me a child till he is seven and I care not who has the handling of him after", they would realise that schools, except nursery and in

lesser degree infant schools, have little important effect on the emotional development of the child, at least where the foundation has started soundly. In that case the teachers of those older children would find it easier to feel blameless for the difficulties of their charges, and more willing to ask advice about what they can do in these unfortunate circumstances. Naturally this fear of the blame which may be laid to their door does not apply to more than a small minority of teachers. Most are keen to help, and where the problem seems one which cannot be solved in school, to accept expert aid from outside.

So with the courts. A first-hand contact with magistrates and the clerk to the court and the possibility of getting across to them a psychological point of view is of paramount importance. Psychologists are often accused of using a vocabulary of their own, which is the merest jargon to the lay mind. One must admit that it is sometimes sadly true, but at the same time, even where the language used is that of simple everyday speech, the ideas which one attempts to convey so often concern what is beneath everyday appearances that if transmitted at second or third hand they may become either the merest travesty of the original meaning or are translated by the uncomprehending into a very poor joke.

We feel, then, that it is of very great importance that the clinic should be as free as is compatible with sound administration to draw its cases from such sources as care to refer them. These sources may perhaps be best considered in three groups, representing roughly the social groups to which the child belongs : the home, the school and society at large.

So far as the home is concerned, it may be the parents themselves who make contact independently, having gleaned their information from newspapers, friends or some social advisory centre such as a Citizens' Advice Bureau or a women's institute or other club ; the parent then comes along with the information that he or she has heard of the clinic from

this or that person or group. But on the whole it is common to find that the parent has gone for advice first to older established and better known medical persons or institutions, and the doctor examining has been the person to suggest, either immediately or after some investigation, that the child is suitable for a child guidance clinic and that the symptoms, whether physically expressed or otherwise, are psychological in origin. In this way cases appear through the family doctor, the hospital or the welfare centre in young children. Usually this is a great help, as one gets the detailed medical information of either out- or in-patient investigation, and is free to disregard completely physical symptoms, however they may be stressed by parent or child; but occasionally where investigations have been prolonged or repeated, and especially where varying opinions may have been expressed in the parent's or even the child's hearing (and either or both of these is clinging to the safe anchor of a physical and therefore uncontrollable disability), the investigations may be a difficult problem to surmount. Especially is this true when the position is that there is some physical disability, but one which is exacerbated and overlaid by a psychological one; so that the two have to be treated concurrently. It is so much easier to take a bottle of medicine than to readjust one's attitude to life.

The last way in which the clinic may come to the parents' notice is through the school, and this brings us immediately into the second group. It probably matters little whether the teacher or the school doctor suggest that the parents make contact with the clinic themselves or whether after the parents have been consulted and have given their consent such contact is actually made by the school; but what should be very clearly understood is that it is a fatal mistake ever to refer a child without first getting the parents' consent. Many a case founders on just this rock, and many a precious hour is spent on getting over the antagonism aroused in the parents, who arrive saying "I never asked to

come here, I don't know what it is all about", and one finds that in truth the difficulties in school have never been reported to them. The parent therefore becomes suspicious not only of the clinic but also of the school. One knows, of course, that it is often done with the best of intentions, because the teacher or doctor feels that it is of the first importance that the child should have help, and fears, often too rightly, that there will be opposition from the parent; but it is safe to say that it is a piece of deception which is almost never successful.

Apart from this the school may operate either at the parents' instigation, because he comes for advice from the school about some difficulty at home or outside and the relationship between home and school is happy enough to permit of his seeking advice in this natural quarter, or the position may be reversed, and the school be troubled by the child's symptoms, and discuss the matter with the parent. Finally, the parent may produce the problem, physical, intellectual or emotional, to the school doctor or at the school clinic.

Sometimes, however, the difficulty is referred from the central source — the education authority. This may occur because the responsible person in the education office is the first one to consider that the case may be a psychological problem. To cite one or two examples: discussion between an inspector and the head of an art school, who were considering the case of an abnormally shy boy of fifteen whose shyness was interfering with the whole of his progress, resulted in his coming to the clinic; a headmaster reported a boy for running away from school in the year following a very exceptional school certificate taken very young, and after a previous perfectly normal school record in this respect; the local authority had a child committed to its care, and asked would a foster home or an institution be more suitable and what sort of job would appear likely to be successful, and so on. These few examples will suffice to

show how such a source may be the most natural mode of reference on occasion, though at first sight it would appear to be a roundabout one. As in the case of a medical reference, if all the information available is included in such a one it may save a great deal of misunderstanding and delay.

Finally, there is reference from other social groups. Apart from medical reference which has already been discussed, this is usually the result of anti-social behaviour in either the child or the parent, and the commonest source is the legal one, either court, probation officer or police. It may be that the parent has gone to police or probation officer for advice without the case coming before the court for an open breach of the law; and this is of course the most satisfactory way for child, parent and clinic. Though our juvenile courts are very different from what they were, though there is an attempt to modify and limit legal procedure and jargon, it is yet undoubtedly true that the fact of coming before the court is one which in the sensitive or abnormal child is liable to produce harm, because of the reaction to the child and in the home. His anxiety, guilt and shame may be over-compensated in a parade as a hero before his mates, and thereafter he tends to remain the same kind of hero, since he cannot afford to let it go; the parent may use the threat of a repetition in order to control him by fear, or may regard the mere matter of having been to court as a disgrace which can never be wiped out, and the delinquent as the family 'black-sheep'. It is to be feared that the average parent whose child gets into the juvenile court still sees in it a place little different from the adult one, and further regards a sojourn in a remand home or an approved school as precisely the same as one in prison.

The general public, in this, as in the question of mental disease, is at least a generation behind the law. Once a child has got into court, it may be the magistrate who either suggests to the parent or makes it a condition of probation that the child attend the clinic, or the probation officer may

advise this later on his own initiative. Occasionally a difficulty may be encountered when, without an initial consultation, such a condition of probation is made. It is obvious that a medical clinic cannot be expected to treat a case which it does not consider within its scope, and that the question of whether a case is a psychological problem or not must ultimately rest with the personnel of the clinic, as also the further question of whether the problem being there, it is treatable. It is only rarely that such a difficulty arises, but it is one which needs to be borne in mind in an awkward case.

Aside from the courts, the other social agencies are, in the case of younger children, such bodies as those which care for children in institutions, the Waifs and Strays Society, Dr. Barnardo's Homes and the like, the National Society for the Prevention of Cruelty to Children and other voluntary societies, including more recently those concerned with refugees. In the case of older children the agencies are the employers or those responsible for welfare at work, whether welfare workers, nurses or others.

It seems important to add here that no child guidance clinic ought to be confined to children just within school years, that the pre-school child is of the first importance especially since he is at the most malleable age, and that the post-school adolescent is always a person in whom difficulties arise even in the normal and is at an age where many major emotional problems may become established or stand a chance of being adjusted. It is for this and many other reasons that one pleads for clinics large enough to provide evening facilities for the workers and the secondary school adolescent, since in neither case is it desirable to transfer them to the adult clinic, where they may so easily, at a most unstable period, hear all sorts of symptoms discussed in a very undesirable way, or even run across patients in a state of complete mental upset. This may prove a major disaster to an already failing stability. Nor can it easily be prevented

in the average adult clinic. The patients wait in a common room, and it is sometimes found, even where the clinic works by appointment, that the morbid curiosity of patients forces them to come early in order to discuss and hear discussed their own and other's symptoms. The upper age limit for child clinics should for preference be eighteen years of age.

One last source of cases is important; that is the religious bodies. Whether such cases come from priests, ministers or rabbis, whether they come from clubs or groups of young people, or whether they come from the moral welfare societies matters little. What is of the first importance is that it should be understood by all that it is no part of any real psychological work to play the rival to religion. Quite the contrary. Religion is a motive force, often the most powerful motive force in the lives of children and adolescents; and even if and when one disagrees with the teaching the child is receiving, to add to his conflict by setting up a rival authority is to do him no service. Far better attempt to understand and modify the authority either as it actually is or as it has seemed mistakenly to the child, and if this cannot be done to leave the problem alone.

TYPES OF CASES

Let it be said immediately that in our view a child is a complete personality, not an aggregate of body, emotion and intellect or any group of terms which may be better liked. A motor-car is not just an assemblage of parts, but an assemblage of parts working integrally together, and the motor may cease to function or may function unsatisfactorily not because there is anything wrong with any individual part, but merely from failure of integration. So with the human being. Further, the motor-car may be in perfect condition, but unless the driver knows his car and drives it with understanding and skill, he will perhaps fail to get it to go at all, and at best will only get an incomplete response

from its potential capacities. So with the human being: the adult must understand himself; the child must be understood by those whose job it is to train him and must be allowed to learn to understand himself.

In summary, the common problem with which the child guidance clinic is called upon to deal is this failure of integration. The component parts, body, emotion and intellect have been taken as a rough summary because these are terms within the psychological pre-view and not because they are necessarily better than any others.

The failure of integration may show itself by the appearance of breakdown in any of the component parts, but examination of that part may prove that of itself it is sound. One or two examples may help to illustrate this point.

A boy of fifteen was referred for enuresis — a physical symptom. He had been under physical treatment at intervals for many years. He had been circumcised, his urine had been investigated many times, he had been treated more than once by a very eminent urologist. The physical machine was perfectly sound. His intelligence quotient was found to be 94, and his mental age 14·9. His intellectual machine was sound. There was no history of mental breakdown, nor were there any symptoms of emotional disturbance, except in the home, and these had hitherto been lightly regarded. He worked satisfactorily, he was liked at his boys' club, he had become an air raid messenger and turned up for his duties. Where, then, lay the trouble? He was an illegitimate child whose mother was antagonistic to him, mainly, one felt, because he existed and was a living reminder of her own mistake. She had married, but had no other children and the stepfather also resented him, perhaps at least partly because he had no son of his own. Although the bed-wetting was frequent he himself was the first to offer unwillingly an explanation of a night when it had not happened: "I had a nice evening at home yesterday, I didn't have any row with my father, he was nice to me." On one

occasion the parents went away for a few days and he stayed with a neighbour who liked him and whom he liked. There were no wet beds, except — the last night of his stay.

A girl of fifteen was referred for failing at school. She had entered the secondary school from an elementary school and had obtained a good place, but her work was not keeping up to this level. Her physical condition on examination was good and she was developing normally. Her intelligence quotient was 143. Her intellectual powers, therefore, were first class, she was capable of attaining the standard of a good honours degree. Yet it was questioned whether she would get a school certificate. Where was the problem? She was one of two children, having a younger brother. The father, who brought her, carefully explained that of course the boy was brilliant, and could scarcely be persuaded that the patient also came within that category. Later she herself complained that there was no point in her bothering about school since Daddy never looked at her reports, he was only interested in her brother's. At another interview she gave another clue to her upset. She was in the midst of an adolescent religious fervour and attended an Anglo-Catholic church though her family were Nonconformist. She was particularly attached to the Blessed Virgin and often addressed her prayers to her. I asked her why she found this so helpful and how she thought of the Virgin. To which she replied: "She is the Mother who always has time for me." I said, "Hasn't your own mother?" "Mother is always busy," she replied in a grim little voice.

There are then three main groups of problems with which from time to time we may be called upon to deal: the physical, the intellectual and the emotional.

The physical problem may present itself either as a physical symptom of hysterical origin, or as a physical habit disorder.

Examples of the former are attacks of sickness. One little girl of seven used regularly to have such an attack at breakfast-

time. She would get up apparently well, but by the time she reached the breakfast-table she presented the picture of a child with a bad bilious attack. She was pale and sweating, quite unable to eat. This persisted and it was impossible to send her to school — it had indeed been tried and the school had sent her back as 'unfit to attend'. By the time it was too late for her to go in, the symptoms began to clear up and by mid-morning she was well. Further, she declared she wanted to go to school and liked it, and went quite happily in the afternoon. After a while it came out that what she was afraid of was the morning assembly, and when she was allowed to miss this feature of school life, until she felt herself ready for it, all the symptoms disappeared.

Vomiting attacks are probably the most common of physical symptoms, while a variable deafness and squint may also find their place in this group. It should be clearly understood at this point that in no case should such a symptom be considered as psychological until all the physical possibilities have been excluded; but it is true that there still remain a residue of cases where there appears to be no organic basis. As an example, a small boy developed a gross strabismus suddenly after a heavy air raid and had many other evidences of emotional disturbance. Among adolescents, fainting is relatively common, and occasionally attacks simulating epilepsy. Some of these may be extremely difficult or impossible to distinguish even over a considerable period.

Of the physical habit disorders by far the commonest is that bugbear of parent, school, doctor and psychologist alike, and not least the child himself, namely, enuresis. Perhaps its importance as a psychological symptom amenable first and foremost to suggestion is best illustrated by the remarks of a contributor to a discussion on the subject at the Royal Society of Medicine, who said that experimentally he had treated cases with belladonna, bromide and coffee, to all of which there appeared equal response. Much less common

are faecal incontinence or diurnal enuresis. Other habit disorders are sleep disorders, food fads and stammering.

Two interesting examples of the last two may serve to show how they arise. The first was a mother who brought a small boy of six because he was said to be losing weight and would not eat. She produced a long list of things which the child was said not to eat, at the end of which she added: "In order to tempt him to eat his dinner I have to give him a little sherry." Such an extreme is of course rare, but in milder forms the anxious attitude of the parent is often largely responsible for the child's behaviour, since it so clearly shows him just how easily he can gain attention in this way.

In the history of a stammerer of very high intelligence another mechanism is shown. This little girl had been handed over to her grandfather and aunt when the next baby was born, as the mother felt unable to handle the two. Afterwards, according to her story, she could not hurt her father by taking the child back. A third baby came later and still the eldest remained out of her own home, to which she nevertheless paid visits. When I saw her and asked, as I often do, if she knew when the stammer was worst, she replied without hesitation: "When I'm talking to Mummy." Consciously she had no wish to return to her own home, she was fond of her grandfather and contrasted her own surroundings with the condition of her home. But her jealousy of brother and sister was shown in many remarks, and her underlying antagonism to the aunt who had brought her up shown in an irritability and scornful criticism towards her and her habits.

This case leads us on to the next group, the cases which are referred for intellectual difficulties. The girl referred to above had an intelligence quotient of 158, one of the highest ever referred to the clinic, yet she was not doing well at school, and on enquiry felt that her best subjects were drawing and needlework. She thought she might be a dressmaker. This type of case is in the group

of those who are afraid to succeed and one feels that, like the case referred to earlier in the chapter, it was because she had so failed to attract the love of her parents that she could not accept success in other directions. The determination to fail as a revenge is shown in a boy of sixteen, who openly said when kept at school after attaining school certificate in order to take it again and get a better one: "I just shan't do any better next year". This boy, born after the father had deserted, was consequently rejected by the mother, who was partly conscious of the position. He was desperately unhappy at home and made matters more difficult by hiding his misery behind a cloak of indifference, bad temper and negativism, which hid the real situation and provided an excuse for the behaviour and feeling of others towards him.

Occasionally one finds that phantasied emotional values have become attached to intellectual pursuits and that failure occurs not because of intellectual inability, but because of the emotional conflict. One little boy, intellectually capable, sat several times for a school entrance scholarship. He did well in the oral part, but the first time was entirely unable to sit for the written examination. Later he said that he could do the examination if he might write in pencil because he could not use a pen. This proved subsequently to have an important emotional basis. This sort of failure may occur even before school. A little boy of four was referred because he was not talking. He was thought to be backward, but was found on investigation to be of superior intelligence (intelligence quotient, 115).

Finally we come to the group whose symptoms are more directly in the emotional sphere, including nervousness and anxiety, tempers, delinquency, sexual misbehaviour and so on. In considering this group one feels that the normality of certain types of behaviour which are socially undesirable should be made clear. Children are not born socially adjusted at an adult level, and it is as normal for them to be aggressive

at one age as it is for them to have to learn to talk at another. Other types of behaviour are often treated far more seriously than they deserve, and such treatment is felt by the child as an injustice and resented accordingly. A boy, left in charge of the distribution of the school tuck who took occasional pennies from the proceeds, a piece of dishonesty only made possible by the slackness of the school secretary in not checking the returns, was threatened with expulsion. One wonders how such an idea could have commended itself as a solution of the problem. Another case is of a father who brought his little girl aged nine, for lying. Her phantasy life was rich and varied and she had little child companionship and the main part of the ' lying ' was of this romancing type ; but she did in addition lie to cover her misdemeanours, for which her father admitted he had often thrashed her. It was impossible to get him to understand that there was any difference between the one and the other, to understand the relationship between a fairy story and the child's phantasies, or between his own day-dreams and her phantasies, and equally impossible for him to see the naturalness of lying to protect yourself from punishment. Finally the direct question was put : " Do you never tell a lie yourself, Mr. X ? " " Only in business," was the reply, " and of course that is quite different."

Pilfering, too, is a type of misbehaviour which adults often measure by a standard far removed from that by which they judge themselves, or perhaps it might be more accurate psychologically to say that they find relief from their own guilt in this respect in their censure of children's behaviour. At any rate, one feels that the attitude of many adults to it suggests that they have conveniently forgotten their own escapades in childhood.

The close relationship between anxiety and aggression is also an important feature of children referred sometimes for one and sometimes for the other, and two illustrations will serve to show how the two are interwoven.

The first was a little boy referred at the age of four for being unmanageable, with violent tempers. He came into the room, walked up to the gas fire and said: "I'll spit your fire out." He received the reply quietly given: "All right. Carry on." He suited his actions to his words and tried hard for some moments unsuccessfully. He was then shown the toys in the cupboard and invited to choose which he would like to play with, but he merely said, "I'll stamp on your toes," and again proceeded to carry out his threat. Finally he began to play with lumps of 'Plasticine' as balls, to the danger of the glass partition, wall and the windows. This excessive aggressiveness was a response to the demands of his parents for a much more adult standard of behaviour than he was ready for, and also to a lack of proper outlets in play. He came for treatment, and it was suggested further that he would probably be better if he had opportunities with other children at school. Unfortunately the parents did not persist with treatment once the immediate difficulty was relieved. Three years later he reappeared, this time referred for nervousness. He was now afraid to go to bed in the dark, or indeed to go upstairs; he peopled his darkness with ghosts and burglars. He was also afraid to come down in the morning unless someone was there first. His aggression had disappeared. In the interval also his mother had died, and one wonders how far this had contributed to the difficulties.

The second case came under observation since the War. The child was referred from an outlying district, whither the family had removed as their own house had been rendered uninhabitable by bombing. The complaint was that he was running away from school and could not be persuaded to go, and the reason given that he was afraid of the other boys who, so he said, bullied him and teased him because he had a blind eye. In the course of the first interview he talked about his old home to which he announced he would like to return, and described the raid. "The back of the house

was blown in, but we were under the stairs; there were bombs all round and Mother was afraid, but I wasn't. I wanted to go and see." As we went on I asked if he ever had dreams, knowing from the mother that he had recently suffered nightmares. "Yes," he said, "I dream about the invasion." "And what happens?" "I see the parachutists coming down, German ones." "And what do you do?" "I get a gun and shoot them. Mother is afraid of an invasion, but I'm not."

No account of the types of problem referred would be complete without referring to the group of problems associated with sex development. Many cases of this kind are referred, varying from masturbation and sex curiosity and play in early childhood to the more complicated problems of adolescence, whether in the nature of real sexual experiment or of masturbating or homosexual phases. It must be left to a later chapter to try to explain how and why sexual problems do arise and what is normal and what is abnormal in the course of the evolution of maturity. Suffice it to say here that of all questions which parents bring, none evokes greater anxiety than these, and that whatever we think of the problems, viewing them from a scientific point of view, it is essential, if we are to gain that all-important co-operation of the parents, that we remember that they have been brought up in the religious beliefs and social traditions of their generation and view these matters from that point of view.

Child guidance work is always complicated by two factors which do not occur in psychological work with adults and which we feel are often insufficiently recognised by therapists handling children. The first is the inability of the child to tolerate certain truths as the maturer adult can, and the second is if the antagonism of the parents is aroused by teaching or interpretation given to the child, and repeated by him either in a moment of aggression — 'the doctor says' or because the parent expects the child to tell him what has transpired in the interview. In such cases the home will be

exercising an opposite influence against which it is almost impossible to work. It is in the realm of sexual matters that this most frequently occurs, either by the therapist giving sexual information without first obtaining the parent's permission to do so, or by interpreting symptoms on Freudian principles in a way which may be perfectly true, but for which neither parent nor child is prepared.

'More haste, less speed' is an axiom which might well be the watchword of all therapists handling children in this way. We need to remember the amount of conscious and unconscious guilt relating to sexual matters which appears in the treatment of adult patients and to relate this to the parents of the children we treat, in order to estimate properly just what their resistance is likely to be to bald interpretations of ideas which they themselves have firmly relegated to the unconscious.

Finally, one must mention the possibility of cases of true psychotic mental disorders occurring in children. This is rare. One finds it most often during the strain of adolescence, especially among highly intelligent children or in developing defectives. The commonest type is undoubtedly the early schizophrenic case; and only the future will show whether anything can be done by psychological methods with cases of this type at this stage. During this period, too, one may get the psychosis resulting from a congenital syphilitic infection, developing. Such cases may show stigmata of infection, or may be obscure. They are unsuitable for psychological treatment, indeed so far they have proved to respond badly to any treatment.

Real neurosis in the ordinary sense of the word is rare, though early signs are common enough. Definite phobias are most often met, but occasionally obsessional symptoms also occur, and one little girl was unable to go to bed without a most elaborate ritual of folding her clothes, arranging chairs, pillow and bedclothes, with all of which her mother had to assist.

REPORTS

No chapter on clinic administration would be complete without a discussion on the question of reports. The clinic is on difficult ground here, because of its twofold function, the medical and the social. In ordinary circumstances, a doctor reports only to a doctor or in the case of children also to the child's parents. In psychological cases, even with adults, it is not always necessary to give full details in reporting a case, and frequently the patient requests that one should not do so. But however that may be, such details as one feels it important to report are conveyed from one colleague to another under the inviolable seal of a professional confidence.

But in child guidance work this is not so simple. All sorts of people, as we have seen, refer cases, and naturally enough want to know what has happened to a child whose difficulties they have thought it right to have investigated in this way ; but since they are not always aware of what is meant by medical confidence, these reports have to be carefully considered. Moreover, it frequently happens that neither parent nor other adults regard a child's confidences as sacred in the way in which they regard an adult's, and we often find that both at home and at school it is insisted that the child should relate what happened at the clinic, with the inevitable result that resort is made to fabrications. Where justices are unfamiliar with child guidance procedure, and a clinic is not yet an established entity, juvenile courts too are sometimes offenders in this respect, broadcasting the contents of clinic reports in open court and sometimes permitting their further publication in the Press.

Such procedures cannot be too strongly condemned. It makes it impossible to give full or helpful reports, since one is uncertain how they will be used, and the inevitable result of a child feeling that his trust had been betrayed would be the defeat of any possibility of achieving an adjustment.

One example will serve to illustrate this. A boy was referred for pilfering and running away from school. He had been placed on probation with a suggestion from the magistrate that he should attend the clinic. Towards the end of the probation period he revealed in the clinic that he had latterly been stealing systematically and successfully for some time. It must be clear that the child had confidence in the therapist to be able to tell the truth. The case was discussed, and a meeting with the probation officer arranged. We reported that we were not satisfied with the child's progress and, in view of the circumstances, felt he would be better away from his own home. The case was brought up before the court and we sent a strongly worded report embodying this feeling and recommending certain lines of treatment. The report was ignored, the child put on a further period of probation. Had we felt able entirely to trust that the confidential nature of our report would be respected we could have given more details; but since this was not so, a serious mistake was made. The child returned to the clinic next day relating all that had happened in high glee, and feeling more than ever that honesty was undoubtedly not the best policy.

Yet, in spite of all this, reports must be sent, and they must give some idea of both the cause of the upset, the capacities of the child, the nature of the proposed treatment and the results expected. So far as possible they should be free of psychological or medical jargon, irritating or incomprehensible to the lay mind, and not of the type once referred to by a magistrate, who said that the only lucid sentence in the psychological report he had received was " this boy has red hair ".

But the initial report, important though it is, is not all that is necessary. Ideally, interim reports should also be sent. Psychological cases are apt to hang on for a long time, and the outstanding problems to vary, and if one is to maintain the interest of others in the welfare of the child, and

its special needs, this is an important part of the handling of the case. In a busy clinic it is a difficult matter to keep track of this aspect of reporting, yet it is a valuable part of the relationship and should never be lost sight of. Moreover, such a review of long cases at regular intervals has another use in assessing progress and, if necessary, modifying treatment, and needs to be done for this reason too.

Finally, it is eminently desirable to report on all discharged cases and, if possible, after following them up, however this may be arranged. A frequent complaint that one hears is 'that one never knows what happens to a case referred to the clinic'. It is true that the complaint is not one-sided. We, too, have frequent cause to grumble about this same thing; and perhaps remembering the annoyance and frustration which the lack of information produces with us, may help us to realise the importance of seeing that our own job is properly done in this respect.

Chapter Four

General Causes of Maladjustment

In considering the causes of maladjustment it is necessary to consider the following main factors: (1) the process of emotional development; (2) the possibility of conflict within the personality; (3) the possibility of conflict between the personality and the environment. Chapters Five and Six are concerned primarily with the last factor — the external conflict; here we are considering the first two.

Although at first sight it may appear irrelevant to discuss normal development in a chapter concerned with maladjustment, we shall find in practice that this is not so, and that such a study repays us in two directions, first because only if we understand what is normal can we begin to assess abnormality, and secondly because in the bringing-up of children one of the common difficulties is the failure to recognise that certain traits may be quite normal in children at particular stages of development.

What, then, are the essential differences between the new-born baby and the mature adult? The most striking is the complete dependence of the infant, and, in comparison, the wide freedom of the adult — a freedom which is physical, emotional, intellectual, within the person, and social and economic without.

The second and closely associated difference is the need of the child for security, and the capacity of the adult to live in an atmosphere of relative insecurity. It is clear that a part of any normal development is the process of adjustment in these two respects, the capacity to tolerate some degree of insecurity, to take certain risks, and to enjoy independence and freedom as a compensation. But this latter carries with it a third important difference between the child and the

adult; namely the relationship between the individual and the society of which he is a part. The infant is the complete individualist, caring nothing for the needs of the society in which he lives, intent only on gratifying his own needs and desires; and the price which the adult pays for his freedom is that of an acceptance of a relationship with society and a measure of responsibility towards it.

It would be clear that in the development of the child and the process of adapting himself to the adult phase of life, there are many and varied opportunities for the growth of conflicts both within the personality of the individual and between that personality and society; and that many fail to achieve maturity in a full degree, and merely achieve a physical and possibly intellectual appearance of the mature, with or without economic independence, instead of that adaptation to the forces within the personality and acceptance of both them and of the demands of society each in its relative sphere.

On the physical plane life is a simple matter for the infant. His food is of one kind and obtaining it needs little effort or skill on his part. He is moved from place to place and kept warm through the care of other people; but in growing up he has to acquire many kinds of skills which need the co-ordination and integration of various parts of the physical make-up.

So on the psychological level the child is endowed with certain hereditary faculties, some which function immediately, and others which only develop with the process of growth. First in the scale are the instinctive fundamental needs and desires which demand immediate gratification, parts of our primitive make-up shared with the lower animals and which are more firmly rooted in us than any of the later superstructure. They are concerned entirely with the gratifications of the individual, and oblivious to the needs of society. By the time the infant has achieved the toddling, prattling stage we begin to see a new force in him. Already

he has become aware of the demands of that society, and therefore has awakened to himself as an individual, a person within it. He has also achieved his first steps, in a very literal sense, in independence. He can get where he wants, he can say what he wants, he can reach and touch what he wants. All this is in a limited sense, but it nevertheless puts him in the way of discovering that his wants are not always gratified, that they may meet with opposition and frustration at the hands of other people. He realises in himself two forces — I want and I am, — either accepting society or in opposition to its frustating power. These forces may also be in opposition to each other, the one demanding gratification of primitive desire for the comfort and security of infancy, the other enjoying the freedom of the two-year-old, and prepared to accept its attendant responsibilities.

Then at the next stage, the demands of society, usually in the shape of the parents, show themselves in approval and disapproval of certain lines of behaviour. The child learns gradually that many of the things he wants or does are not liked by the adult world, and since he has no clear distinction in his mind between himself and his outward behaviour, dislike of what he does is dislike of him. He is not loved if he does this or that. It is not astonishing, since one of the threats of the 'grown-ups' is often 'I shan't love you if you do that.'

As a result there develops another force in the personality represented by the idea 'I ought', which is really 'I owe to you', and is associated with a sense of guilt, or in popular parlance learning to know right from wrong. This third internal force is built up gradually and in the first instance entirely from the precepts and injunctions of parents and teachers, and through them of the Churches. It is frequently at variance with, and in open opposition to, the child's knowledge of what he is and of what he wants, and the conflicts which it arouses may be fierce enough to stultify harmonious growth and prevent use of capacities

and energies which he possesses. Moreover, its own growth is liable to inconsistencies, since, unfortunately, the 'ought' of the different mentors is not always the same, nor is it consistent with their practice. So there comes a startling moment of awakening, when the child becomes aware that the adult, whom he has been regarding as a god, omniscent and omnipotent, perfect, is a fallible mortal like himself, and the security on which he has been building no longer holds. It is difficult to put a date to this awakening which in happy homes is a gradual process of unfolding, but it may occur with startling suddenness even in early childhood where parents or circumstances prove undesirable.

Obviously this is a very crucial point in the development, and one where the child has to make a great choice, the choice between refusing to allow himself to know what he has discovered and remaining a child, or of admitting the facts to the bar of his own judgment and accepting direction of his own life. It has sometimes been assumed that at this crisis the child loses all love for his parents, and that one who continues to love them has of necessity failed to grow up; but this would seem to imply that he, too, cannot learn to distinguish between their failings or the fact that they do fail, and themselves as persons, and is therefore retaining a childish attitude. Naturally, it is possible for the parents to be unacceptable people; but it is not necessarily so, nor, though they must be accepted as fallible, must their experience always be refused. It does, however, set up possibilities of a further conflict between the 'I ought' as accepted from adults hitherto, and 'I ought' as the child begins to see it for himself. Later, in grown-up life one can often see this conflict in people who have one standard of living for themselves and another quite different one for other people. Often they take a pride in this, and many people regard the practice of intolerance to oneself and tolerance towards others as a mark of virtue.

General Causes of Maladjustment

We have now in brief outline a summary of the forces within and without the growing child, each struggling for its own fulfilment; and since all are parts of his life, which must be kept in harmony if he is to use to the full his potential powers and achieve maturity, it will have become clear that the causes of maladjustment are in the conflicts between these forces, and that this may be either because certain fundamental needs are not provided for, so that there is no foundation from which to start development, or because the personality is unable to solve the conflict and must deal with it by other methods.

Before we begin to consider the actual conflicts which may occur, it may be well to discuss briefly the part played by heredity in the developing personality. In the previous section we have already considered this when discussing the psychiatric interview with the parents; but since obviously poor hereditary endowment may be of importance in the inability to develop, it is perhaps not out of place to mention it again. Clearly, it is true that just as the children of parents of poor physical or intellectual endowment are likely themselves to be stunted or frail, stupid or slow, so children of unstable parents may inherit the same poverty. It is not always so; intellectual giants may be the children of mediocre parents and, conversely, genius may produce defect. Nevertheless, the balance of probability is the other way. The intermingling of the factors of heredity and environment makes it difficult in any given case, since, to take two examples at random, an over-protective mother may have a dependent child because the child has inherited her own inability to tolerate the insecurity of independence, or alternatively because he cannot free himself from the possessiveness by which she assures to herself the continuance of her own security; again, an over-ambitious father may have a son who like one child said he wanted to be a doctor, "but father only wants me to be a herbalist"; or one, like a young man who made no success of his work, for

which he had ample capacity, because as he said "I dare not go beyond father". In the first case the son must go beyond father's ambitions, in the second he cannot constitute himself to revolt, but in both the same drive to success is present as in the father and is in direct relation to the feeling about him, and correlated to personal desires and interests.

The two most fundamental needs of the human personality are those of security and freedom; and their importance to the person reverses in the course of life. It will be clear that freedom matters relatively little to the infant in the first year (though we recognise nowadays the value of physical freedom to kick) and that security matters everything. But we are far too apt to assume that at this stage security means only physical safety and the supplying of physical needs, and that because the child can only show his emotions in terms of the physical he has none. There are two points here: first, that emotional relationships are very important; secondly, that the reality of these feelings can at this early stage only be accepted on a physical level.

Some people's experience in child welfare clinics appears to suggest that when mothers are reluctant to breast-feed their babies or are resentful about it, the babies thrive better if transferred to artificial feeding. Harmony is then restored, and the baby, from being unwanted, is accepted by the mother. Yet the mother's milk, on analysis, is apparently good. Recently this suggestion of an emotional factor obtained some further confirmation from an adult patient who was unable to suckle her own child and could not understand why she had no milk, since she said, "I ought to have had some; we wanted Vera, and I had always thought of a baby snuggling up". Clearly in her mind, the emotionally conscious desire should have had an effect on the physical capacity. Is it too much to suppose that there was an important psychological element in this, and that breast feeding is as much an emotional as a physical contact, and the first lesson in the art of mutual give and take? It is clear,

too, that infants are aware of being handled by strangers, and that even where the handling may actually be more skilled they show their feeling of insecurity by crying or clutching.

Psychological security is based on the feeling of being acceptable and accepted, and for each of us this must start with our being accepted by our parents, and where this is lacking or is felt to be lacking, there is a poor foundation on which to start. Thus in the stories of the children who come to us for treatment there is a relatively high proportion of unwanted pregnancies, of babies who were the opposite sex to the desired one, of illegitimate children and of children who have lost one parent, especially the mother, at a very early stage. Foster parents, adopted parents, step-parents bring up such children often puzzled, secure in the knowledge that they have done their best, that they have loved and cared for them, and yet they have no success. It is uncommon for them to understand that the damage to the child's sense of security, to his trust in the adult world around him, was done before ever they came on the scene, and that it is almost true to say that the kinder and better they are, the worse the loss appears to the child.

An adult patient once said of this situation as she had known it: "What made it worse [the fact of being aware that her mother did not love her] was that Grannie and Auntie always spoilt me." The situation resolved itself for her with this: "There must have been something wrong with me if my own mother couldn't accept me." This feeling of not being wanted is certainly the most important single factor responsible for a sense of insecurity; and let us be clear that it is not necessarily, nor always due to any parental 'fault'. For the feeling of being deserted may be produced equally by untimely death or actual desertion, the feeling of not being wanted or of being thrust out in the cold by such accidents as being of the wrong sex, or a baby born in a period of disaster or a premature child. Besides all this, there is the element in the child himself, who may be constitutionally

tough or tender ' and the same handling thus have entirely different effects.

Then there is the problem of the coming of the next child and of its sex. Because of this apprehension of things on a physical basis, of this awareness of things in the concrete and lack or incompleteness of awareness of either emotion or ideas in the abstract, children's conceptions have a logic of which the adult is often totally unaware. Thus it is possible to play a game in a room using furniture, carpets, etc., as either armies in the field, or woods through which a stream runs, or a schoolroom with a class of children and a teacher, but not possible at this stage to imagine these things without some concrete object.

So with emotion, it is represented and felt in terms of the concrete — gifts, embraces and so on — and therefore if there are two of us I can only have half the love, just as I can only have half an orange. The child thus naturally dislikes the newcomer and feels that he would not have come had the parents found him satisfying, and if the newcomer is of the same sex, that he himself cannot be a satisfactory specimen of that sex; if of the opposite, then clearly this is the reason why the first one was unsatisfactory. All this may sound far-fetched, and many will say that it is just ridiculous and that jealousy is the exception between the children in a family. My experience has been that it is extremely common. To find that it has come out in the open, accepted, and that wise handling has helped the child through it is a stroke of good fortune, for assuredly to deny it is to close our eyes to facts because they do not fit our illusions, and to encourage the child in the repression rather than the facing of a natural feeling.

We have here used a technical expression which perhaps, since it has come to be rather loosely used, needs some clear definition. Repression is the forcing-back of impressions formed in the mind together with all their attendant emotions.

These are pushed out of consciousness; but since no release has been allowed to the tension which they engendered, they remain like an unexploded bomb in the recesses of the unconscious, liable by some inadvertent movement, some new constellation of events, to be 'touched off' when the original exciting cause has been long forgotten.

Nor is it only relationships with brothers and sisters which raise difficulties. There is also the very important factor of the relationship with the parents. The classical myth of Oedipus has been used by Freud as the prototype of what may happen in the early sex life of the developing child. Of Freud's theories perhaps this is the one which has roused the most heated and bitter discussion. Yet from the memories of adult patients, from the effects of sexual experience such as assault, from the observed attitude of children towards parents of the same or opposite sex, we have ample evidence of the truth of the contention that children are sexually aware in an infantile way before the age of five, and that this sexual awareness is commonly to be observed in relation to their parents. One or two illustrations may serve to demonstrate this point.

A very intelligent girl of fifteen lost her mother at the age of six. She remembered saying to her father, "Now I can sleep with you and keep house for you." When, eighteen months later, he brought a new wife home, she was very angry, openly told her she hated her and became a problem in the household. At fifteen she was in an approved school, and at seventeen, when last heard of, she was in prison.

A boy of eleven, whose father was a bad character who had deserted the home and lived promiscuously, was very angry because his mother, in order to make ends meet, took in lodgers and they were men. They were apparently kind to him, they gave him pocket-money, they were willing to take him out, but his antagonism was implacable, and he was rude to them, stole from them and successfully got rid of several in this way.

Another girl of twelve, whose mother separated from the

father when the child was two, has only recently discovered that he is not dead. She makes reckless phantasies about him and schemes to seek him out and introduce herself to him, her own explanation being, " he may like me even though he doesn't like mother."

Quite apart from cases of this kind, the same process in modified form is clearly evident in the generally accepted idea that girls are fonder of their fathers and boys of their mothers ; in the fact that adolescent girls are often heard to state that they want to marry someone like daddy, and that the first love is quite often either of his type or its complete reverse ; that we occasionally find son or daughter who so remains fixed at this stage that he or she does not marry in order to remain with the beloved parent, even though opportunities occur ; in the open hostility and rivalry which often occurs between mother and daughter, and less often, except in early stages, between father and son. Recently a case was referred where the mother after her first husband's death married his brother. At once what had been a friendly relationship between uncle and nephew disappeared and open hostility took its place.

Finally, if we are to take the view that there is no sexual awareness in the little child, how shall we explain the plain fact that where children suffer actual sexual interference or assault, they commonly do not voluntarily go to their parents and tell them. It is frequently true that children will go home and tell mother that teacher has caned them, much less frequently true that a girl will tell her that a man stopped and put his hand up her knickers or forced her to touch him. It is surely natural to assume that the child does not tell because already there is a taboo on such matters and therefore a sense of personal guilt about them, and further that the guilt is accentuated because, mingled with the guilt, there is an awareness that along with the fear the occasion caused there was a measure of pleasurable excitement.

But there are other factors which may also play their part

in shaking the child's sense of security. Among them is the important question of physical illness. Physical illness may bring an emotional disturbance in its train in three ways. First, it may have distressing and painful symptoms which it is impossible to relieve. Such, for example, may be the distressing paroxysm of whooping-cough or of croup, or the pain of cutting a tooth or of an ear-ache. The inability of the adult to help, or the inefficiency of his attempts to do so, provide an emotional shock for the child who has regarded him as omnipotent. He is faced with the difficult alternative, either the adult too may fail or he does not want to help. Secondly, physical illness or accident may involve inevitable separation. An infectious disease may occur, or a street accident, and the child be taken straight to hospital. He may be unable to say who he is or where he lives, and it may be some time before the parents are located. Meantime many things are done, often inevitably, but unfortunately not always with that understanding of this side of the child's make-up which would minimise the psychological injury. Often it is the first separation from home, occurring just when the child is least fitted to face it; and if, in addition, a new member of the family should arrive during this absence, the feeling of rejection is complete.

Thirdly, the emotional trauma of physical incapacity may be of a different sort, produced by an illness or disablement which of itself makes the child inferior to, or unable to share in, the pursuits of his companions, or makes him the object of their derision or fear. Disfigurements play a part in this last group. A small boy was afraid to go to school because he had been nicknamed 'Wall-eye' on account of such a misfortune. The nicknames 'Carrots' and 'Fatty' are other such examples. Cleft palate with its speech difficulties presents another. Of those illnesses which limit the child's physical capacities, the outstanding are acute rheumatism with its attendant and chronic heart troubles, and paralysis of various kinds, but especially birth palsies and acute

infantile paralysis. One small boy, with a birth palsy of his right arm, so that he was left-handed by necessity, but probably not by structure, began to be delinquent at the age of seven. At this age he transferred from an infant to a junior school, to find himself alone among boys. Through his school life he was quiet and shy and solitary; and in a burst of confidence one day he admitted that he could not really play with the others since, if it came to a scramble or a fight, he knew he was no good: "I have only one arm."

On the intellectual side too, difficulties may arise which make normal development an uneasy task. Of these, real backwardness is the most obvious; for the backward child, slow to grasp new ideas and with difficulty in expressing himself clearly and accurately, the ordinary school must soon become an unsatisfying experience. It is impossible usually for him to attain any success and therefore to feel any encouragement. What wonder if he turns his attention to more satisfying pursuits, to tricks in class that gain him the admiration instead of the derision of his companions, to running away where at least he has a pleasurable day whatever may be the later outcome, to delinquency where he may prove a king in the rifling of gas meters and be the honoured member of his gang. Punishment is going to be no deterrent, for in these exploits at least he has both the goodwill of his mates and the pleasure of the episode, whereas in school he is faced by a task in which he is a failure and for which he may in addition be punished because he fails, and the laughing-stock of all.

Though it occurs less commonly, it is sometimes true that real intellectual superiority is the cause of difficulty. It is assumed that with this intellectual capacity there goes also an emotional adjustment equally beyond the average, and it is expected not only that this will be so, but that it will be associated with powers of leadership and a capacity for responsibility to match. Thus, a boy of fifteen, who had obtained an extremely good School Certificate, was in con-

sequence placed in the sixth form, made a prefect and expected to go on immediately to Higher Certificate work, though he would not take it for three years. Brilliant intellectually, he had an intelligence quotient of 157; but he began to fail at school and to run away. On enquiry, it was found that he spent his time as truant in the city library reading light fiction (his own particular subject being mathematics). He explained that he now hated school; he had wanted and had not been allowed to have a year free of Higher Certificate work and to do some woodwork and games. The sixth form did not welcome this young upstart in their ranks, none of his own friends had got there; and, most difficult of all, his authority as a prefect was nil. Frankly he was bored. The circumstances of this case were unusual; but it is true that behaviour problems and sometimes real delinquency occur because such children have not enough to do, and emotionally are less fully developed than they are intellectually.

A boy of eleven who had got a place in a Central School, began to run away in his last term at his old school. He was good intellectually, and his father, for some minor escapade, tore up the form he should have filled in about the new school, and told him that since he could not behave he should not go. Yet it was clear that the behaviour had occurred because there was no longer any opportunity or, for him, any purpose in the old one.

Besides these sources of conflict, there are also more deeply rooted internal difficulties of adaptation which come from the child's relationship with himself, and more especially from his fear of his own impulses. Certain of these, he quickly learns, are disapproved of by the adult world; and, since the approval of that world is so essential to him, he must check such impulses. Further, his own sense of guilt, his self-criticism or super-ego, comes to reinforce the disapproval of the outside world, and the stage is then fully set for the repression of these forces within him.

Thus a child who in his early years learns to be afraid of his aggressive desires, because they have called out against him disapproval and punishment, passes from the stage where he acts and speaks as he feels, to one where he does not allow himself even to formulate a thought or express a feeling within the consciousness of his own mind. An adult patient who was a *ticueur*, with so violent a bodily movement that she sometimes actually hurt herself with it, remembered in the course of treatment that she had had a series of such tics in her childhood, for which she had been taken for medical advice; but that she herself had known that the movements had been a way of expressing her anger and hatred of her mother in a way which could not be described as naughty. In the interval she had dissociated the tic from a conscious awareness of any aggressive desires and thought herself as feeling none. Most unwillingly she came to recognise that actually the movements occurred whenever there was any sort of occasion for annoyance or anxiety.

Aggressiveness is one of the traits appearing in the developing child which is most liable to such repression, since it is one which is regarded unfavourably by the adult world. Popularly it is described as check, wilfulness, obstinacy, temper and so on, and it is not often understood that what is being admitted by the use of these terms is that the child has reached a stage where he perceives himself as an individual, and as such challenges authority. It is this challenge to his authority, this wilfulness, to which the adult objects, and so it is regarded as itself a sign of badness rather than a sign of health. Aggression, like all our instincts and the primitive impulses proceeding from them, is both good and necessary to healthy life; and if they are stigmatised as bad the child represses them and splits them off from the rest of his personality so that they remain undeveloped and infantile, and they are, in the person, a liability rather than an asset. In other words, the person whose aggression has in this way been repressed is as maladjusted, as lame in his

psychological reactions as he is lame physically if he has lost or damaged a leg. Further, in both cases the matter does not end here. The inability to use a leg throws the body out of balance and results in secondary changes in the other leg, in the hip girdle and in the spinal column, etc. So too with the psychological sphere, the inability to use a primitive impulse results in a twist of other things in the personality. Thus, for example, all powers of leadership or initiative, or creative work, depend partly on aggression, just as much as acts of quarrelling and destruction, of murder and war. It is clear that such a force needs to be dealt with by means other than seeing only this second side and responding: "thou shalt not." What is required is direction and control, so that the energies which need a vent may be able to find it in constructive rather than destructive ways, or since we probably all at times need a destructive outlet, that such destruction occurs in harmless forms.

There is, however, another of the deeply rooted impulses in the child which arouses his fear again both because of his awareness of its strength within him and of the attitude of the adult world to it, and this is the vexed question of sex. Consciously the repressive attitude towards this may come to the child's consciousness as a result either of his curiosity or as a result of observation of adult behaviour about this matter, their sense of guilt and shame arousing corresponding feelings in him, or because his behaviour, sex play alone or with others, rouses their open hostility.

All children are curious, indeed all healthy minds are curious. When we no longer want to know, it may well be said that the springs of life have dried up within us. On the whole, parents realise the importance of answering questions, with two reservations. There are relatively few who can admit ignorance, who can 'fail' to answer, who have got the courage themselves to step down from the pedestal of omniscience and help the child to realise their and his own fallibility by being able to admit it openly and with the

partnership corollary: "Let's go and find out together," so further admitting the naturalness and rightness of the desire to know. But the second reservation is even more important, and it is this: such questions must not touch personal problems which they themselves have never really faced. Foremost among these is the problem of sex. The tendency here is always to repress the natural curiosity; but to set enquiry in this direction in an entirely different category from other curiosity, and to treat it as a matter for plain lying in the various stories told to children, or to regard the child as something unpleasant or bad because he has shown this curiosity, is plainly absurd. Sometimes the natural questions in this direction are, however, repressed before they are uttered, because it becomes clear from the behaviour of the adult that they would never be answered. Injunctions about privacy and prudery in the grown-up world may be the factors prohibiting such queries; but so also may the witnessing accidentally of adult sexual activities and the resultant emotional storm in the child. Finally, masturbation or open sex play with others, trying to find out how things work, are often treated as evidences of a depraved nature, as signs of disease of either physical or mental nature, and so both fear and guilt come to find a place in the child's mind with regard to these desires and activities, and since they are so taboo and yet so demanding, they are first hidden in the recesses of the unconscious and then resumed vicariously in other activities, which themselves are regarded as harmless both by the outside world and by the tyrannical conscience, or to use the psychological term 'super-ego' within.

Aggressiveness and sex curiosity may be regarded as two major sources of conflict; a third important source of conflict may be the emotions aroused by the desire to succeed, the desire for power — important because of its tremendous value as a motivating force and because of the social attitude towards success and failure, and also towards expressed awareness of success. This latter point is perhaps

particularly important in Great Britain, where 'putting on side' or 'swanking' is regarded as something which just is not done, and we are all the time expected to 'hide our light under a bushel'. If we watch small children who live in a free atmosphere, we see that they are what we call entirely unselfconscious in this matter, they openly and simply show you what they can do and are proud of their attainments. Two things happen to disturb this; first, the attitude of society to it, and second, the fact that it is fashionable to belittle and cry down your own achievements. Well-adjusted adults probably always only give lip service to this fashion, and within themselves have a just estimation of their powers; but this is not necessarily obvious to the child, who comes to accept the standard of society for himself and allows his own self-criticism to assure him that he really cannot do this and that, and so gets to the stage where he is shy, diffident, uncertain and self-conscious. Thus he fails because he dare not succeed, lest success should bring the label of a swank, or pretends to a failure where he should have enjoyed a success, thus feeling frustrated and baffled.

Certainly there is truth in the idea that 'humility is something which ceases to exist just as soon as it is mentioned' and that the dishonesty of this attitude as well as its disappointingness produces a sense of frustration and depression. But it also frustrates the natural desire for power and admiration which is in each one of us in greater or less degree. Children are often very aware of their feebleness, physical and intellectual. In order to compensate for it, they show off. They make phantasies of greatness or power; they are royalty or police, they are lions or engine drivers, they are teachers, mummies or daddies. Sometimes this is intolerable to the grown-ups because the child depicts with too deadly an accuracy either their outward behaviour or its springs in unconscious thought; sometimes it produces conflict because the child in his phantasy character demands

an acceptance from the adult which the latter cannot bring himself to give, or because the child treats younger and more helpless mates with a roughness which come from his joy in the relative power that he has achieved, and with a fair imitation of what he feels to be the adult attitude to him.

One mother complained bitterly that her small daughter was always playing games of beating; she beat her dolls, she made the chairs into a school and beat the children and so on. She was surprised and indignant when, on asking how she punished the child, and she responded, "I give her the strap", it was pointed out to her that the child was simply echoing her own behaviour. This desire for power is also revealed in another piece of behaviour, universal and quite normal in young children, the inability to admit failure. It is this which produces a great deal of childish lying and some pilfering; and this which makes it generally true that small children cheat to win. It is far more a sign of abnormality in a child not to mind losing than it is for him to cheat, though the first is considered a virtue and the second a vice. This trait is normally grown through as the child is allowed to realise that adults too may fail, as he observes that they can accept this; and as he achieves some measure of success himself. We are far too chary of recognising and accepting those successes which he does manage. We are unwilling for him to feel secure in his own success, to feel, as we term it, self-satisfied, and herein lies perhaps one of the worst errors in the handling of children, for it is only when we feel secure that we are in a position to go forward and take a further risk, and this security which originally we get from our parents, we must ultimately carry forward in our knowledge, and acceptance, of ourselves. In crossing a stream, if we are to get to the other side, we must let go of the bank; but we can only do so as we feel steady on the first stepping-stone, and we can only move from each of these to the next when we have at each stage satisfied ourselves of the steadiness of our balance.

Chapter Five

Causes of Maladjustment in the Home

It is generally agreed that most serious maladjustments and personality difficulties, other than those with direct physical causes, have their roots in early childhood and are either caused, or at least aggravated, by wrong handling in the most impressionable years. Of those responsible, parents are by far the most important both numerically and influentially. Often they are themselves maladjusted individuals, who, by reason of their own unresolved problems, are unable to avoid handing on a legacy of trouble to the next generation. It follows that every case of maladjustment in the home presents a problem of infinite complexity, and that the subject of this chapter is in reality co-extensive with the whole realm of abnormal psychology. Only those aspects which are of direct concern to the psychiatric social worker in a child guidance clinic will be dealt with here. For the psychiatric social worker it is important to be able to recognise and remedy those features in a family situation which seem to be the immediate cause of maladjustment in the child, rather than to seek out the remote origins of the parental inadequacy, though, as will be shown in a later chapter, this may sometimes prove necessary.

Let us first consider those problems which arise out of the attitude of the parent towards the child. Perhaps the most frequent problem met with under this heading is that of the unwanted child. By this is meant not only the child who was unwelcome from its conception, or who has become unwanted through unfortunate circumstances, such as the death of the mother and the introduction of a stepmother, but any child who for one reason or another has failed to come up to parental expectations, and is therefore made to feel

an outcast in the family. It may be merely that it was not of the sex desired, or not up to the required standard of intelligence, or the parents may see some resemblance to an unappreciated relative, with whom they proceed unconsciously to identify the child. Whatever the cause, it is impossible for such a child to feel the security which is fundamental to its emotional well-being, for the very basis of such security is an unquestioned sense of belonging to, and being loved by, its parents. Where this is lacking, a variety of psychological disorders may appear, depending on the circumstances and temperament of the child. The following case offers one example :

The parents had been married for many years without having a child. They were anxious for a son, more for reasons of family tradition than from any particular love of children. They had, eventually, a daughter. This was a great disappointment, but, determined to make the best of it, they had her christened Pauline, and called her Paul at home. To add to their troubles, she was a sickly baby, and cried almost incessantly for the first six months. The father's health suffered through lack of sleep, whilst the mother, never robust, and no longer young, found that looking after such a baby in addition to her other duties was almost more than she could manage. It was not long before they heartily wished they had never had her, and looked back on the fifteen peaceful years of their marriage as a veritable paradise lost. When Paul was barely three her mother brought her to the child guidance clinic, declaring that she was a hateful child, and so rough that others would not play with her. " In fact she is not like a little girl at all. . . . When she won't play with her own toys, she's always wanting to butt into our conversations. . . . We get no peace with her." Here we have a picture of the unwanted child, pathetically trying to force herself on the attention of her parents, even to the extent of simulating the boy that they had wanted, yet only antagonising them the more by her efforts. Fortunately in this case

it was possible to break the vicious circle by enlisting the support of the father, who showed considerably more sympathy and understanding than the mother. But such cases are not always so successful, for the change of attitude must come first from the parents, and it is usually difficult and often impossible to get them to see that their rejection of the child is the cause, rather than the consequence, of the latter's deficiency.

Those who have not been trained to observe underlying psychological factors often fail to recognise problems of this type, for the rejection is seldom open, and is often skilfully camouflaged and may even be unconscious to the parents themselves. The problem is still further complicated by the fact that it is unusual to find a parent simply rejecting a child and wholeheartedly wanting to be rid of it. More often there is a conflict of love and hate, both sentiments existing simultaneously and succeeding one another in consciousness in the alternating moods of the parent, who is then said to be ambivalent towards the child. This fact of ambivalence, though often baffling to the observer, is of course the most hopeful element in the situation, for the latent love is the only possible foundation upon which a new attitude can be built. Where such a basis does not exist all efforts to produce a change of attitude will be successfully resisted, for the parent is not really interested in the child's cure.

Another problem very often met with is that of the over-protected child, whose mental and emotional development is hampered by the fact that his parents are afraid to allow him the necessary freedom to take risks. Sometimes even this may be due to an unconscious rejection of the child, accompanied by strong feelings of guilt which give rise to an over-compensation in the form of extreme solicitude. On the other hand, the over-anxiety may be due to the fact that the child is the only one and in consequence the focus of the entire parental affection, which too easily becomes possessiveness. Or it may arise from some early weakness in the child,

necessitating a care which is continued long after its cause has been outgrown. In one such case the parents had lost two girls in infancy. Many years later a boy was born, to their great joy. At the age of about a year this child had a serious illness which alarmed the parents to such a degree that they were never afterwards able to regard him as normally robust, and continued to coddle him to an absurd degree, constantly warning him against over-exertion, and refusing to allow him to play out of doors for fear he should catch cold. The effect upon this particular child was to produce a somewhat exaggerated reaction towards toughness and masculine aggressiveness. Had he been less fundamentally robust the effect might have been quite different and even more unfortunate. Then again, many mothers find it difficult to face the fact of their children growing up, and the desire to keep the child a baby may be at the root of the over-protectiveness. This naturally occurs most frequently in the case of an only child, or the youngest of a family.

In the cases of both over-protected and rejected children the parents are usually found to be more or less neurotic. Parents who are neurotic may, however, react in a variety of other ways, making use of their children to work out a spurious solution of their own problems. Thus one mother who brought her boy to the clinic was found to have had a very exaggerated devotion to and dependence on her own mother. In spite of this she had married against her mother's wishes; but she was never able to overcome her feeling of guilt, nor quite to accept her husband, who she felt did not come up to her mother's social and intellectual standards. She was determined that her children should be worthy of their grandmother, and drove them on to attempt successes far beyond their intellectual capacities. Such modest success as they did achieve they were never allowed to enjoy, for in her eyes it was inadequate, and equivalent to failure. It was her eldest son, on whom her ambitions particularly centred, who was brought to the clinic as being nervous, priggish and

unable to mix. She described him as unbearably "superior" and complained that it was "like having a head teacher in the family". It was found at the clinic that the boy was unable to face failure or to admit himself in the wrong — hence he could not of course risk mixing with other boys on equal terms, particularly as he was rather a poor specimen physically. In this case the underlying cause was clearly the mother's neurotic conflict. She had disobeyed her own mother in marrying the man of her choice, and now, though her mother had long been dead, she was unconsciously sacrificing her children's happiness in the attempt to propitiate her. It is not unusual for parents who for one reason or another are obsessed with a sense of failure to develop an overwhelming ambition on behalf of their children.

Sometimes, without being neurotic, a parent may, by reason of some temperamental peculiarity or onesidedness of development, be unable to respond to a child in the way which it needs. Thus a well-known artist, a born Bohemian, confessed that he could not believe in, much less sympathise with, his son's perfectly normal interest in school life. Or again, a very intelligent and successful professional woman who was also the mother of several children, once observed that she had made a great mistake with her eldest boy. "I looked after him myself," she said, "and I brought him up perfectly as regards physical development. Then when he was about a year old I realised that I never talked to him. Somehow it had not occurred to me to do so." To the mother of predominantly intellectual type 'baby talk' may seem somewhat absurd and difficult, even if recognised as necessary. Such women often find babies and young children very boring and are therefore incapable of responding adequately to their emotional needs.

Or again, without there being any neurosis or serious personality defect, a parent may adopt a wrong attitude simply through ignorance. Cases of this sort are usually easily remedied. Some children are more difficult than

others, and not every parent can be expected to know by the light of nature the best way of handling the problems they present. This is particularly the case with such nervous habits as nail-biting, bed-wetting or stammering. One mother who brought her boy to the clinic for nail-biting, confessed that she had tried everything — punishments, rewards, threats, persuasion, ignoring him, "showing him up" in front of the neighbours, and finally making him wear gloves — but still he was no better. If a parent's first attempt to deal with a problem is unsuccessful it seldom improves matters to try a variety of other methods in rapid succession, thus adding to the original mistake the even worse one of inconsistency. In this way the child is bewildered, and as his anxiety increases the symptom is likely to become worse instead of better, whilst the parent, oppressed by an increasing sense of failure, becomes less able to view the problem in its proper perspective. In cases of this sort, some explanation of the possible underlying causes of the symptom, together with advice as to a consistent line of conduct, is often all that is required.

Occasionally a wrong attitude towards the child arises out of a lack of principles in the parent. An experienced psychiatrist once remarked that he had never come across a dishonest child who came from an honest home. This was perhaps a safe statement, for few parents would claim to be entirely honest, and those who did would certainly not be. Nevertheless it is unfortunately true that there are many whose standards are distinctly below the general level, and it is not surprising if their children are socially maladjusted. The following is a case in point:

A child named Mary, who was not very intelligent, arrived at school one morning wearing a watch which her classmate Gladys had lost the day before; but when questioned by the teacher she insisted that her mother had given it to her. The mother when sent for apologised profusely, agreed that the watch must be Gladys's, but declared

that no one was to blame, for she herself had picked it up in the street a fortnight previously, and not knowing whose it was, had given it to Mary. This story was easily refuted, as the watch had only been lost the day before. But clearly a mother who could in the first place acquiesce in her daughter's wearing an obviously stolen watch, then tell a story in front of the child which the latter knew to be false, admitting in the course of it that she herself would not hesitate to appropriate an object of value found in the street, could scarcely be expected to bring up a socially well-adjusted child. A child's earliest notions of right and wrong are founded on what he feels his parents would approve or disapprove. If then by their actions they show approval of what is commonly disapproved, it is not to be expected that the child's morality will harmonise with that of society.

Too rigid principles on the other hand also have their dangers, for they may be the bigoted expression of an unbalanced personality. Such is the extreme puritanism which regards humanity as essentially depraved and all its pleasures as sin. One adolescent girl who attended the clinic had been driven to serious delinquency as a revolt against her high-principled parents, who, with the maxim that Satan finds some mischief for idle hands to do, had reduced home life to an endless round of dreariness and drudgery. Such an attitude is rare in these days, and usually only found in association with some serious neurosis; but a widely distributed legacy of puritanism still persists in regard to sex. Some parents are convinced that children ought to be kept in entire ignorance of the subject until adolescence at the earliest. The resulting unsatisfied curiosity, and the feeling engendered by the parental attitude that such curiosity is wrong and ought not to exist, is the cause of much painful emotional conflict, and may be the foundation for a variety of neurotic manifestations.

These are only a few examples of common errors in the bringing-up of children which can lead to maladjustment.

They occur, however, frequently enough to make many people ask if it is not true that the parents are always to blame. The answer surely is that since most of these faulty attitudes are either unconscious or held through ignorance or a genuinely mistaken belief, it is scarcely fair to *blame* the parents concerned, and more appropriate to consider them in need of help. On the whole, parents to-day tend to be highly self-critical. The social worker is constantly faced with such questions as " John has always wet his bed. I suppose it must be my fault, will you please tell me what I've done wrong ? " or even " Judy has taken to stealing. I'd like to know whether it's me or her dad that's the cause of it." Often indeed it is quite difficult to convince parents that the child's trouble is not entirely due to some culpable error on their part. Usually, then, it is safe to assume that within the limits of their understanding the parents have done their best. Where this is not so, there is little that can be done at the child guidance clinic, for they are almost certain to reject the services offered.

So far we have considered only cases in which the attitude of one or both parents towards the child was at fault. But there are other defects in the family situation which may be no less detrimental. For example, it may be that the relationship between the parents is unsatisfactory. To a little child even an argument between his parents can be distressing, for he naturally believes that both are infallible. How, then, can they disagree ? Open quarrelling in which each may accuse the other of every kind of baseness is of course immeasurably worse, for the child's sense of security is shattered if he cannot believe that both his parents are at least fundamentally good. Where such quarrelling is habitual the child usually comes to take the part always of the same parent, and is thus virtually deprived of the other. Sometimes in doing so he is forced into a semi-adult role in relation to the one he champions. Thus one small boy who was the witness of frequent violent scenes between his parents

came to regard himself as his mother's protector, as indeed she expected him to be, though he was able to yield her no more than a precarious moral support from his refuge under the kitchen table. Mother and son were a pathetic pair, each looking to the other in vain for a source of security.

Brothers and sisters can also play an important part in causing maladjustment. A certain amount of jealousy and rivalry is so general as almost to be regarded as normal. In particular it is recognised now that the unexpected arrival of a younger brother or sister can be a cause of serious disturbance, more especially to a child who has been for some years the only one. Here of course the attitude of the mother plays an important part, for if she has tactfully prepared the child, and is careful to avoid giving the impression that all her attention is now centred on the baby, trouble is less likely to arise. Sometimes in a large family a child in about the middle tends to feel squeezed out and insignificant, having neither the privileges of the older ones nor the extra care of the younger, and he may as a result develop compensatory symptoms. Or again, it often happens that the youngest child becomes maladjusted, particularly in families in which the others are considerably older. Such a child, coming after a long gap, when the mother is no longer young, is often both unexpected and unwanted. He grows up to feel himself an interloper in an already complete family, and whether he is treated as such or is made a pet of by his brothers and sisters, he is still apt to feel hopelessly inferior. In one family of seven children, the last, a girl, was nine years younger than her next sister. By the time she was ten years old this child, in an attempt to emulate her older brothers and sisters, had adopted an extremely grown-up pose. Her very appearance was unchildlike, and she had a stiff and pedantic manner of speech. In addition she had developed a number of symptoms, including night terrors, the unconscious purpose of which was to secure extra attention from the mother.

The only child presents a special problem. Normally

it is in his relationship with brothers and sisters that a child first learns the give-and-take of social life and becomes conscious of himself as a member of a group. No sort of relationship with adults can be a substitute for this experience, for the necessary equality of status is lacking. The children of a family, despite their different ages, talents and privileges, are essentially on an equal footing, particularly in relation to the parents whose love they have to share. It is thus that they learn to ' break the shell of their own egotism ', a difficult task in the best of circumstances, and all but impossible for the only child. Nursery schools can do much to provide companionship and training in co-operation, but they cannot solve the problem, for still in the place that really matters, where all his strongest feelings are centred, the child remains alone — without a rival, but also without a friend. Such children do not perhaps present more than their share of the grosser forms of abnormality; but they would appear to account for a higher proportion of those who throughout life manifest certain subtle and deep-rooted defects of personality, such as self-centredness and parent fixations.

Parents, brothers and sisters, or the lack of them, are not, however, the only sources of trouble in family life. Relatives outside the immediate group can often exert a pernicious influence through their well-meant interference. Grandmothers in particular have much to answer for, so often do they appear to take advantage of their position of power without responsibility to undermine the authority of the parents. In one family a small girl of seven used to use it as a threat against her parents that she would " run away and live with Gran " if they did not comply with her every whim, and in fact she did so on several occasions, sometimes taking her younger brother with her. " Gran ", who lived only in the next street, was always ready to receive them, with evident satisfaction at the preference shown for her. In this case there was no peace until the family moved into another district.

Causes of Maladjustment in the Home

So far we have dealt only with families whose basic structure of father, mother, and child or children, was normal and complete. It is well known, however, that a large proportion of problem children come from what are loosely described as 'broken homes'. It remains to consider various types of such homes which deviate from the normal family structure, and the problems to which they give rise. Illegitimacy, to begin with, is one of the most frequent and serious causes of maladjustment. There are of course exceptions, but typically the illegitimate child is seriously handicapped. Not only is he usually unwanted by the mother and almost always by the father whom indeed he seldom knows, but too often he is despised and insulted by his schoolfellows for what was after all no fault of his. This is likely to affect him in two ways. First, lacking a normal family life, and hearing his mother spoken of with contempt, deprives him of the feeling of security necessary for his emotional well-being; secondly, the fact that he himself is an object of ridicule to his fellows is likely to imbue him with a consciousness of the injustice of society. He will thus be disposed to grow up unstable and anti-social. A poor heredity often provides an additional handicap. Should the mother subsequently marry and have other children the situation is scarcely likely to be improved, for he is then in the anomalous position of the eldest child who is nevertheless the least-honoured member of the family.

In cases of what is known as cohabitation, illegitimacy may present a different picture. It is not unusual to find the parents living together for many years or even permanently and producing a whole family of illegitimate children. In such cases there is usually some obstacle to marriage; probably one or both of the parents are already married, and the difficulties and expenses of divorce appear too formidable to be contemplated. There may even be all the fundamental requirements of a happy home, nevertheless injury to the

children arises through the attitude of society if the irregularity is known or suspected. In one case of a girl from such a home, who was persistently playing truant from school and staying out at night, the father was encouraged to make use of the Poor Persons' Procedure to obtain a divorce, after which he married the children's mother, with whom he had been cohabiting for many years. The child's feeling of security was thus restored, and her behaviour became much more normal.

Where the parents merely neglect to marry through contempt for social conventions, the child may also acquire the habit of flouting those conventions which appear inconvenient to him. He may steal, for example, or stay away from school, very often to the surprise and indignation of his parents, who can see no possible connection between their own conduct and that of their child.

Divorce and legal separation are merely the outward and visible signs of the inner disintegration of the family. They are not likely to be more injurious to the children than the discord which preceded them. On the contrary they are probably less so, for they arise out of a courageous facing of the facts, and are inevitably explained to, and probably accepted by, the children. Though the child's security within the family may be shaken, he is not made to suffer in addition persecution from without, since such legal decisions are socially tolerated.

The loss of one or both parents through death is a deprivation about whose consequences it is difficult to make any generalisation, so much depends on the individual child, and on the behaviour of those in whose care he remains. In general it would appear, as might be expected, that the loss of the mother causes a more serious shock than the loss of the father. The child guidance worker, however, usually meets the problem in its second stage, after the introduction of a stepmother or stepfather.

The 'wicked stepmother' has become a legendary figure,

and not without reason, for a stepmother occupies a position which few women seem able to fill satisfactorily. Admittedly she has usually a difficult and unenviable task. The children with whom she has to deal have suffered not only from the shock of their mother's death, but often also from a lack of care and discipline in the interim period. They are predisposed to resent another usurping their mother's place, both with regard to authority over them and in relation to the father. A girl in particular is often bitterly jealous of her stepmother, for she had secretly hoped to take her mother's place in her father's affection, and to be in fact mistress of the house and guardian of the younger children. Hence the children start antagonistic to the newcomer, and soon have abundant opportunity of comparing her unfavourably with the mother, by now idealised in memory. At the same time, any hostility which they may at one time have felt towards the real mother is apt to be transferred to the stepmother. Then again, the attitude of neighbours, and more particularly of the dead mother's relatives, is usually unhelpful. They often encourage the children to look for trouble, warning them that they need not expect a stepmother to treat them as their own mother did, and undermining her authority whenever the opportunity arises. The stepmother herself, aware of the weight of tradition against her, and conscious that there are some at least who would not be sorry to see their worst expectations fulfilled if she should prove to be no better than her fairy-tale prototype, is apt to start with a feeling of inferiority. This may find expression in aggressiveness, but more commonly, to begin with at least, it leads to an extreme diffidence in asserting her authority. She hopes to avoid trouble and to find favour with everyone by adopting an easy-going manner. To her surprise and indignation this effort at appeasement is not appreciated by the children, who interpret it as weakness, and give full reign to their feelings of resentment, sometimes refusing to obey her, and becoming generally out of hand. The stepmother

in her turn is no longer able to suppress the antagonism which is almost bound to be latent against the children whose presence is the cause of all her trouble, and whose apparent ingratitude has frustrated her good intentions. A vicious circle is thus set up in which any child who is seriously involved will inevitably suffer a greater or less degree of emotional disturbance. Should the stepmother in due course have a child of her own, the position becomes much worse ; she may now give up all pretence of mothering the stepchildren, and frankly admit that they are in the way. The latter in their turn find that they now have to share their father with a new rival, and this time one who is on the same footing as themselves. They thus feel more than ever displaced. It is not unusual to find children in such a position staying out at night, running away from home or even committing offences in the hopes of being sent away. This, of course, is particularly liable to happen if the father is unsympathetic.

Occasionally one comes across cases in which a stepmother has been able to deal successfully with a difficult situation, usually when she has no children of her own and is really anxious to be a mother to the stepchildren. In one such case the stepchild was a boy of twelve, slightly subnormal in intelligence and very much thrown off his balance by the sudden death of his mother two years previously. Since that time, he had been in the habit of running away from home in an impulsive and aimless manner, sometimes stealing money and food to take long railway journeys, at the end of which he would give himself up to the police and return quite willingly to his father. He was placed in a residential school, but was not a success there and ran away several times. Meanwhile the father had remarried, and the stepmother, who had already won the confidence of his sister, expressed a strong desire to have him home. At first she was unsuccessful, the periodic running-away continued, but she never gave up hope, nor lost her affection for the boy.

Determined to try everything, she brought him to the child guidance clinic, and showed so much goodwill and co-operation in the treatment that eventually the boy accepted her as a mother substitute, and was completely cured. He discontinued treatment at his own request in order to earn money for his stepmother by taking an after-school job delivering newspapers.

The stepfather presents as a rule a less serious problem. Provided he treats the stepchildren reasonably and kindly he is usually accepted. In two types of case, however, trouble is often encountered. The first is where there is a boy who has formed a too strong attachment to his mother, and cannot but regard his stepfather as a rival. The second is where the stepchildren are adolescents whose growing resentment against authority is intensified by the intrusion of yet another restraining influence.

If psychological problems are likely to arise through the loss of one parent, there is probably even greater danger of maladjustment where both are missing, that is to say in the case of adopted children and those in foster homes. Adopted children start with the advantage that they are always wanted in the first instance by the adoptive parents, though sometimes for neurotic reasons. If they are not already maladjusted, there is therefore a good chance that they may find a happy home and never become so. Too often, however, the damage is done long before the child arrives in his new home. As a result of the shocks and privations he has suffered in infancy, he is predisposed to be difficult, and the adoptive parents, who usually know little or nothing of his early life and its implications, may feel both bewildered and bitterly disappointed. In some such cases, lacking the incentive of true parental love and responsibility, they are unwilling to persevere long enough to overcome the difficulty, and begin to regret the step they have taken, and perhaps try to get rid of the child. Finding that this is no less difficult to accomplish than it would have been in the case

of their own child, their resentment increases, and they may even, though probably unconsciously, encourage the child to behave in such a way that he inevitably comes before the juvenile court, and is sent to an approved school. Such parents, secure in the knowledge that they at least started unprejudiced, and believing that they have done their best, are inclined to blame heredity, and to declare that the child must have a ' kink '. It is difficult to convince them that, given patience and sympathy on their part, psychological treatment might effect a complete cure, for, particularly if they have adopted the child from purely selfish motives, they are naturally resistant to any suggestion which will put them to further trouble. One woman of this type explained that she had had a little dog for eleven years, and when it died she had decided to get a little girl instead, but now after her experience she thought she would rather get rid of the child and have another dog.

Quite another type of problem is often met with in adoption cases. The child is adopted in infancy, and brought up by the new (adoptive) parents in the belief that he is their own. They become deeply attached to him, and do not see why he should ever discover the truth. However, sooner or later almost inevitably the child begins to suspect, either through an unguarded remark overheard at home, or more often through the gossip of other children, who have picked up the information from their parents. At first he is incredulous, then doubts begin to arise. He dare not raise the question at home, or if he does he is met with evasion or lies. A painful conflict develops in his mind ; on the one hand he wants to believe his parents, and to be convinced that he is indeed their own child ; on the other hand there is the growing certainty that he is not. Sometimes the latter is thrust out of consciousness, but still persists as a problem in the unconscious, and serious neurotic symptoms begin to appear. Even at this stage the adoptive parents are apt to resist fiercely the suggestion that they should explain the

facts of the situation to the child, so afraid are they of losing his love. Admittedly it is difficult to make a sudden revelation of this sort without disturbing consequences, and it should of course never become necessary. Where the parents take a different line, and bring up the child in the knowledge that they adopted him as a baby because they particularly wanted him, making it clear that they regard him in every way as their own son, then he is able to accept his true position from the beginning with a minimum of emotional disturbance.

Foster-parents, by which is implied those who undertake the care of a child in their own home for payment, present other problems. Such homes are made use of by many social agencies and by local authorities for the boarding-out of orphans, etc., committed to them by the courts as being in need of care. Many of these children, like those mentioned above, come to their new homes with well-established neuroses. No matter how well they may be treated, they will not then behave normally, without the help of psychological treatment. But as in the case of so many adoptive parents, foster-parents are often unwilling to take the necessary trouble, and with more reason, for it was never their intention to accept more than a limited responsibility for the child. They therefore return him to the authority from whom they received him, with the explanation that they " cannot put up with him ". He is then re-boarded out, and the same thing happens again. Finally, he may be brought to a child guidance clinic after having been tried out in half a dozen different homes in the course of a year, in each one of which his behaviour has proved more intolerable than in the last. This was only to be expected, for with each upheaval such a child has his sense of security more severely shaken, and his feeling of being unwanted and an outcast more firmly established. The homes to which he is sent are in themselves usually reasonably good, for they are carefully selected and inspected, but they are seldom suitable

for any child who has shown signs of serious maladjustment. After all, the foster-mother undertakes the care of children primarily as a congenial method of adding to her income. But the payment she receives is little above the cost of keeping them, and she naturally does not regard it as a part of her duty to deal with those who are in need of special care, and likely to make her life a burden for many months, and perhaps do considerable damage to her property. If problem children are to be boarded out, the only way to avoid increasing their maladjustment would be to have a panel of specially selected homes with foster-parents who were not only fully conscious of the task they were undertaking, but who were also given some sort of instruction in the best methods of dealing with the difficulties they were likely to encounter. They would naturally receive a proportionately higher payment in consideration of the extra skill and effort required of them.[1]

Lastly, we must consider those causes of maladjustment in the home which are not so much inherent in the family situation as accidental or economic in origin. It is often asked whether poverty is not one of the main causes of social maladjustment, particularly since the majority of juvenile delinquents come from poor homes. The answer would appear to be that poverty alone, though it may lead to a general stunting of development, does not cause emotional disturbances so long as it is accepted as a part of the normal order. This is usually the case with those who have been brought up in poor circumstances amongst neighbours who are no better off than themselves. Relative poverty on the other hand can have a very disturbing effect. This is often shown when a child from a poor home wins a scholarship to a school where he finds himself amongst children the

[1] Under the Evacuation Scheme the Ministry of Health, following out this principle, has allowed a special billeting allowance to foster-mothers accepting particularly difficult cases under the supervision of psychiatric social workers.

majority of whose parents are very much better off. It is not uncommon for such a child suddenly to take to stealing or playing truant, and when the trouble comes to light he may beg to be allowed to return to the original school, where he had never been made to feel conscious of his poverty.

A sudden lapse into poverty may have somewhat similar effects. In this case the child compares his present circumstances not with those of others, but with his own more happy past. Usually the change of fortune is accompanied by considerable anxiety to the parents, and it is this, even more than the privations which he suffers, which is the cause of disturbance in the child. One of the worst evils of unemployment, from the point of view of the child, is that since it is usually intermittent it leads to this kind of economic insecurity, periods of comparative comfort for the family alternating with periods of anxiety and deprivation.

Closely allied to the problem of poverty is that of bad housing conditions. Where there are inadequate facilities for play there is an inevitable restriction on the child's freedom, and he is driven to find all his recreation in the streets, often in areas where there is little opportunity for legitimate amusement other than going to the pictures. Even this costs money which is not always available. In addition, it is stimulating to a sense of adventure which already has too little outlet. Hence the next step may be joining a gang which specialises in breaking into empty houses, robbing gas meters and pilfering from shops. A child who habitually indulges in such activities may be termed socially maladjusted, though his emotional disturbance is not necessarily very serious, and can often be cured by a change of environment.

Another problem associated with bad housing conditions, though often met with where no such excuse exists, is inadequate sleeping accommodation. Boys and girls are frequently found sleeping in one room, and even in the same bed. Sexual curiosity is thus stimulated, and abundant opportunity given for establishing undesirable habits, whilst

at the same time such children are usually left in complete ignorance of the true nature of the function which they are investigating. The consequences of children sharing their parents' bedroom, though less obvious, may be even more serious, for psychoanalysis has demonstrated beyond doubt that, when even very young children witness in this way scenes which they only partially understand, though they may later forget the experience, the shock which it causes is often the basis of emotional disturbance in later life.

Sometimes, where accommodation is limited, parents seek to avoid the dangers mentioned above by arranging things so that the mother sleeps with a girl, and the father in another room with a boy. This, however, is little more satisfactory, and is apt to hamper normal emotional development, either through fostering a prolonged dependence on the parent, or through provoking resentment in both parent and child. One small boy, brought to the clinic for bed-wetting, was found to be sleeping with his father. It was observed that whenever the latter was away from home, the bed-wetting ceased. It was in fact an unconscious aggressive act, with the object of driving his father away. The boy confessed that what he really wanted was to sleep with his little sister as he had done at one time.

Worst of all, perhaps, are those cases where the parent sleeps with a child of the opposite sex. Occasionally a mother, in particular, is misguided enough to allow her son to share her bed right up to the time of puberty. In such cases the infant's sensual love for his mother is not given the chance to undergo the normal transmutation, and the boy may remain emotionally fixed at an infantile level, with consequences that are fatal to a healthy social and sexual development.

Chronic illness of one or other parent can also be a cause of maladjustment in the child. His home is not likely to be a happy one, for however cheerful the invalid contrives to be, illness inevitably casts a shadow of depression and anxiety

over the other members of the family. If it is the father who is the sufferer there is economic insecurity; if on the other hand it is the mother, there is no comfort in the home. In either case all manner of restrictions and extra burdens are put upon the child. Worst of all, since the ill person cannot bear with the ordinary troublesomeness and noise of children, he is made to feel guilty out of proportion to his misdemeanours. He may even come to feel in some sense responsible for the parent's illness. This was the case with a boy who, after breaking a shop window, appeared before the juvenile court, whence, since he showed signs of nervous disorder, he was referred to the child guidance clinic. It was found that he came from a very poor home, where the mother suffered from a chronic heart disease, and the utmost quietness was enforced upon the children. This nine-year-old boy had reacted by joining a gang which had caused some trouble to the police; but he insisted that the offence for which he was apprehended was entirely the result of an accident. He was found to be suffering from intense guilt feelings over his mother's illness, and was convinced that this incident would kill her. Unfortunately, shortly afterwards she did die, and it was not possible to get the boy to attend the clinic for treatment.

Finally, maladjustment often arises in families where one or other parent is, in normal times, frequently absent from home. Usually it is the father, who may be a commercial traveller, or at sea, or serving in the Forces. The children are deprived of the father's influence, and a common effect is an exaggerated emotional dependence on the mother. This may give rise to a variety of neurotic symptoms, and be accompanied in the case of a boy with a more or less conscious hostility to the father. Normally a boy's desire to replace his father is balanced by his dependence on him, and by the affection and respect arising out of daily contact. But where such contact is only occasional, he comes to feel it not only his privilege but even his duty to take the place of his father

so far as possible. The periodic returns of the latter may therefore give rise to very mixed feelings, on the one hand being welcomed as the occasions for family rejoicing, on the other hand resented as marking the advent of a dreaded rival. One mother complained that her son who was devoted to his father, who was in the Merchant Service, and always looked forward eagerly to his leave, nevertheless became unaccountably bad-tempered and difficult to manage whenever he was expected.

In war-time, absence of the father is of course normal, and does not appear to have quite the same effects. This may be due to the fact that the absence is recognised as temporary, and depending on causes quite independent of the family situation or the will of its members, hence it can be accepted in a more impersonal way. Though not perhaps prone to cause serious maladjustment, the absence of the father on war service is, however, a factor contributing to the increase of juvenile delinquency. Children tend to become out of hand, particularly in those families where the father is normally at home, and the mother has left problems of discipline to him.

Frequent and prolonged absence of the mother is of course a problem rarely met with, but many mothers go out to work by the day, with effects that are far from beneficial to the children. In such cases even quite young children are often inevitably neglected for the greater part of the day, locked out of their homes and left to play in the streets or find refuge with a neighbour who has agreed to ' mind ' them, until their mother returns late in the evening. Even then, tired and with arrears of housework to make up, she has little energy left to devote to them. Quite apart from the fact that war conditions make this state of affairs inevitable, it seems useless to urge individual women to give up their work and confine their activities to caring for their homes and children, for even before the War the trend of the times was in the other direction. The economic incentive to work,

though very important, is by no means the only one, for the more energetic woman does not forget the wider and freer life she enjoyed as a 'business girl' before her marriage, and is eager for the change of atmosphere and varied contacts which can only be obtained in an outside job. If, as a result of persuasion or a sense of duty, she remains at home, too often it is with a sense of frustration and consequent loss of vitality, which is in the long run no better for the children. It seems that the only solution is to accept the working mother as a normal phenomenon, and to see that adequate provision is made for the children. A continuation of the possibility of part-time work for women, with a wide distribution of nursery schools and play centres, would probably be the best solution. For the child under two there can be no satisfactory alternative to the mother's care in its own home.

The causes of maladjustment in the home are so multifarious, and the consequences so serious and often crippling, that it is not surprising that many advocate a general loosening of family ties, and a progressive relief of parents from their dangerous power and heavy responsibility. But it is not likely that the parent substitute in the form of the State, however perfect its organisations and benevolent its intentions, would be any more successful from the point of view of the community as a whole. For the majority family life is the deepest source of happiness, even if there is some conflict of personalities; indeed the very intensity of feeling engendered in the family situation is the dynamic of all creative activity. In mental life at least, conflict is a condition of growth, and though the casualties are many and tragic, the majority who achieve normal development do so through the efforts they have had to make to resolve their particular family problems. It would seem, then, that the parental function of society is not so much to replace family life as to assist or rescue its casualties before irreparable damage has been done.

Chapter Six

Causes of Maladjustment in the School

THE other two chapters of this section on the child's difficulties of adjustment within himself and in his family have given an indication of how his earlier emotional stresses and strains with parents and brothers and sisters are a preparation for the later stresses and strains of social life.

In these discussions on the child's difficulties within himself and his family, it has been shown how an unsatisfactory adjustment inside the home may result in an inadequate equipment for dealing with the problems outside the home. Thus apart from inborn differences of degree of intelligence, potentiality and temperamental quality the child is helped and hindered in varying degrees by the opportunities for emotional development that his home has given him.

For this reason normal situations of everyday life, in school or at work, present difficulties to some children where they are cheerfully accepted and dealt with by others. Instances of such difficulty referred to here are taken partly from experience with child guidance and partly from the observations of children made in school visits; but they are essentially descriptions of the difficulties of the child who in some particular is an exception to the general rule. Any criticisms of existing educational practices or customs are made simply on the grounds of how they affect certain individual children, without any carefully balanced considerations of their efficacy from a wider aspect. It is inevitable that an educational system which has grown up to cater for the large majority of normal children should be inadequate for a minority. It is the aim of this chapter to describe some of the situations which may give rise to difficulties in members of this minority. For ease of description the different stages

in the child's development will be considered separately; there is however no hard and fast line between the stages, and the ages where divisions are made is necessarily somewhat arbitrary.

In normal circumstances the first real test of the child's bearing power is when he goes to school. Then he is faced for the first time with a set environment over which he has no control and which he cannot evade. He has probably been used to finding in his family a spirit of compromise. If he has felt sufficiently strongly about anything and made sufficient fuss he will usually have succeeded in modifying the environmental circumstances at least to some slight extent to suit his wishes or needs. Alternatively, when a situation within the family has become too hard for him to bear he has usually had the possibility of withdrawing from it — playing with some of his own private, real or phantasy possessions in a corner of the room, or wandering alone out into the garden, yard or street. He was thus able temporarily at least to dissociate himself from the reality which was causing him displeasure.

The very young child then is not as a rule subjected to any severe or prolonged strains in the outside world. True he does not spend every minute in the bosom of his family, he meets other children in the street, neighbours demand certain standards of behaviour and probably from his earliest days these are outside influences directed towards his socialisation; but he is usually in a position to evade these demands if they become too tiresome, and to return at will to his home where he is valued for himself. Exceptions to this are the child who at an early age spends a period in hospital and, now to-day, children who at a very early stage are cared for in nurseries.

Little is actually known of the effect of early hospitalisation on psychological development; but evidence from later psychological treatment of children with a history of such early partings suggest that it has more far-reaching effects

than are generally admitted. Similarly residential nurseries for very young children have been in existence too short a period for the effect on the children to be known. Detailed research in this field has been carried out by Anna Freud in the Hampstead nurseries for bombed children, and in these nurseries the prevention of psychological shock through sudden separation from the mother has been an especial study.

The modern free nursery school where the children go daily is designed to make the transition from the liberty of home to the discipline of school a gradual one, prolonged over several years. Nevertheless the restrictions on the child even here are real and unavoidable. A comparison of the daily programme of the three- to five-year-olds in a nursery school with that of the three- to five-year-olds in the home, or in the city street, or village garden shows marked divergences in elasticity. One gives routine, the other freedom.

Perhaps the most far reaching of these differences is the child-adult ratio. Whereas in the home there may be one, or more, adults to one child or at the most to two or three children, in the nursery school one adult may at times be responsible for up to thirty children. In the home the adults are on the whole concerned in their own preoccupations, and may attend to the child only at set times or when it is demanded of them ; in the nursery school the adult has the children as her main concern, and exerts control and restrictions to suit the running of the group as a whole, and her behaviour is not modified specifically to suit any one individual child.

This difference means that in the home emotional expression can be indulged in with moderate safety, at the child's whim, at his own time, whereas in the nursery school expression of emotion between the child and the adult is by circumstances severely limited. Children who realise this as a limitation often make efforts to overcome it through determined demonstrations of overt affection.

Living more intimately with children of his own age gives the child very definite compensations for his relinquishment of maternal care and freedom of movement, but the compensation at first may not be accepted or realised as such. He may remain for a time preoccupied with his loss, realising what he has given up. It is not therefore very unusual to find that a new-comer to a nursery school on the first day remains completely silent, refusing to speak to anyone, behaving like a much younger child, or alternatively expressing his displeasure in a more active form by continuous crying, which may be repeated for several days.

For some children, therefore, the first transition from home to school is a severe shock. To all, even those who show nothing of this, it involves strain in the first days. It is usual, however, for the joys of companionship, and the pleasure in the importance of routine, to establish themselves quickly and for the child to settle down in contentment, missing school in the holidays. The transition is made safer in the modern free nursery school than in the older more rigid infant school by the increased opportunities for freedom of movement and play. After any initial difficulties have been overcome, the nursery school child is able to use these opportunities to the full and to indulge in real creative play with children of his own age. Further, because all children of three to five are emotionally vehement, and often unpredictable, individual abnormalities are accepted and each child is given time and opportunity to become happy at his own rate.

There are only very few who do not achieve this happiness, and often on examination these are found to be children with actual defect who are mentally substantially younger than their years and not ready for the particular stage of behaviour for which opportunity is being provided. Perhaps the only other children who are unable to fit into a nursery group are those who are being excessively indulged in their homes. Such children are easily recognised by the nursery school teacher. They remain incapable of accepting even the

slightest restriction, and are still at such an early egotistic level that they cannot accept the existence of other children. They therefore shut themselves away and refuse others admission even into their phantasy life and behave only grudgingly to them in reality. For such children some psychological treatment running parallel to their nursery school life is usually the best solution. A clinic play group, described in Chapter Eleven, is often sufficient to make the adjustment possible.

An examination of the child's outside world in the nursery school shows a situation which is health-giving even for the maladjusted child. The same is true in the modern infant school. There is freedom of atmosphere and opportunity for each child to develop at his own rate and in his own way.

In the junior school the problems to be faced are somewhat different. It is assumed that the children have outgrown their strongly individual needs and that they are ready to sink their differences and fit into the group both in work and play. In general this is true. The junior school child is essentially teachable. He is spontaneously interested in the problems of reality and has given up the satisfaction of earlier individual needs. The child at this age is ripe for control, accepts the discipline of school work and routine without complaint — and apparently enjoys it. This is the period when the child is prepared to use his developing intelligence, to learn more about reality and to develop finer skills.

This transition from the emotional life of the infant to the comparatively unemotional life of the junior is, however, accomplished in the child only slowly and, in fact, there are some children who go through the junior school without making the reality adjustment of the normal junior school child. This may be because they have never had a chance at an earlier stage to live through their emotional problems or it may be that the junior school conditions are demanding more from them than they can give. If the reality provided

is too difficult then they can gain no satisfaction from coping with it, and sink back for satisfaction into their more infantile phantasy life. This often happens with the children of low intelligence.

The fact that children at this age are interested in obtaining knowledge of the outside world, and are interested in learning school subjects, means that their differences in intelligence standard will have a more marked effect on them than the same differences do in the earlier days in the infant school. In the infant school it is the child's emotional life that matters to him ; it matters whether or not he can express himself emotionally, whether or not the opportunities are sufficient. When all this is put behind him and success in scholastic subjects and a wide knowledge of the outside world become of paramount importance, it is then that he notices himself in relation to others in differences in intellectual capacity. For this reason junior school children are frequently referred to child guidance clinics for difficult behaviour in and out of school, possibly for running away, who on intelligence test show an intelligence quotient often round about the 80-85 level. In the freedom of the clinic atmosphere, and under individual intelligence test conditions, such a child will often spontaneously admit that in spite of the fact that he makes great efforts, he yet does not succeed in doing as well as other children that he knows — and may admit too, that he has as a result ceased to try.

Similarly at this age for the same reason we have children showing anxiety about their chance of success in the scholarship examination and often here a complicating factor is the over-ambitious parent. It is significant perhaps that such anxiety seldom shows overtly in the school ; it takes a disguised form, possibly in difficult or solitary behaviour or sometimes in symptoms such as facial twitch, stammering or running away. In the junior school the child who is not so good but yet who wants to be good has little chance of ventilating his difficulty. In the clinic his criticisms may be

outspoken — " I don't like school because I get hit for getting my sums wrong " — " I don't like school because teacher she shouts at me " — or " teacher she hits the others " — it may simply be — " I don't like school because I can't do the sums ". There may be no dire consequences for this failure ; but it is the failure itself that is feared. It may be " I don't like school because the other boys laugh at me ". In some children the dislike is quite unexpressed — they know they are unhappy at school — they know they evade it whenever possible, but they do not know why.

The joy with which such children greet the facilities for play in a clinic is an indication of what they are needing for treatment. " I didn't know you could play with sand when you had gone up from the infants " — or " We did used to play with toys when we were little ". If this attitude is compared with that of the more fortunate child who has a nursery, and plays with dolls right up to adolescence — often with trains beyond it — and if at the same time it is remembered that many of the children in our schools have little opportunity to play at home and have never known the joy of a real nursery, this may be an indication of those extras which are at present needed in our junior schools.

In the secondary school the bogey of school failure may still remain, for in schools where the children are selected from the junior school for high intelligence and ability, the standard expected is very much higher and the competition for success more marked. There are, too, in some such schools children who have been accepted as paying pupils who are not, in spite of the entrance examination, of sufficiently high intelligence to succeed. They find themselves in the same position as the junior child of low intelligence — they are all the time being asked to live above their intelligence-level and the strain may be too great.

Further difficulties in secondary schools are sometimes occasioned by children from very poor homes who have won scholarships, but are unable to keep up the standard of dress

and social poise required by the particular school. Such children, too, often have inadequate facilities for doing homework, their home background and standards may be so different from those required in the school that they suffer the agonies of feeling different just when they are at the age when conformity is of first importance.

These difficulties do not arise in schools designed to cater for children whose standards are not primarily intellectual. Scope is given for development at the child's own rate and no effort is made to press him beyond his limit. The children who tend to be misfits in such schools are sometimes those who would have profited by a more academic education, but who have not been able to accept it because of the necessity to start earning as soon as possible. Such children are sometimes conscious of their lost opportunity and fail to settle in the school, looking on it only as a compulsory passing of time until they reach the school leaving age.

Further difficulties arise with those children who, often through low intelligence, have been unable to form any stable character structure in early childhood and who reach adolescence without any basis for effortful behaviour. Such children easily drift into the ranks of the delinquents, for they leave school at a stage when they are not sufficiently mature either socially or emotionally to fit into work.

The change from school to work presents for all children new problems for which the school may have given very little training. For example, the child for the first time is earning money and is faced with the attendant responsibilities of spending it. Even when all the wage is handed over to the mother, there is a new power attached to being a wage earner. It means that new concessions are demanded in the home, and if these are not granted, a resultant attitude of rebellion develops. Fresh and more expensive standards of dress are adopted, sometimes entailing spending beyond the resources of the family.

Outside the home the child is faced with the responsibilities of using his new freedom, and in particular with adjusting his behaviour to the opposite sex. There is often little help or advice available to him in his difficulties, and possibly no realisation that the difficulties are there. He is again at the stage where his own instinctive emotional life is important to him, and when it feels highly individual and unique. He has now the problem of bringing his phantasy needs into line with reality, of finding his position in the real world, no longer guarded by the four walls of school or his home.

Chapter Seven

Methods of Examination (1)

WORK OF THE PSYCHIATRIC SOCIAL WORKER

Of the many duties of the psychiatric social worker, perhaps the most generally understood and appreciated is the part she plays in the preliminary examination, for no diagnosis is possible unless the child's immediate personality can be viewed in relation to the heredity and environment which have not only contributed towards it, but must largely determine its future development. It is often impossible for the psychiatrist or psychologist to obtain an adequate picture of the family background solely by interviewing the child's parents and others concerned with him, inside the clinic. At best, such a method is laborious and uncertain, and may involve many interviews, and a gradual piecing together of the various contributions: at worst, there is the risk of undermining the child's confidence in the therapist. This alone would be sufficient argument for leaving such contacts to one who is at no stage of the proceedings directly concerned with the child, and who is, in addition, particularly fitted by training and experience to assess social factors. An exception must of course be made for the one interview with the mother or father which most psychiatrists like to have when the child is first brought to the clinic; but by this time the psychiatrist should have by him the social worker's report, embodying such a clear picture of the problem as a whole that he is able to devote the limited time at his disposal to elucidating the particular points that seem most relevant to his purpose.

Most social workers will try, therefore, to visit the home before the child is brought to the clinic, having, whenever

possible, sent a note to the parents informing them of the time of the proposed visit, and asking for a reply if it is not convenient. Not only does this save much time which would be wasted if there were no one at home; but, more important, it is a matter of ordinary courtesy which is fundamental in establishing the right relationship with the parents. The surprise visit has its uses in certain cases, and is sometimes unavoidable, but it is never a good way of making the first contact, as it almost inevitably puts the parent at a disadvantage. A mother flustered and irritated at having her plans upset, preoccupied with the half-cooked dinner, or embarrassed at being caught with the room undusted and her hair in curling pins, is not likely to be as expansive and helpful as one who is expecting a visit and has had time to collect her thoughts and arrange things to her own satisfaction. Then again, the first contact is all important with regard to any subsequent treatment which the social worker may have to undertake with the parent, and it is well worth a little trouble and forethought to ensure that such a contact shall be as good a foundation as possible, and shall give the impression that the child guidance clinic exists to help parents and not merely to interfere, as is sometimes suspected.

Where the ground has been prepared by a tactfully worded note, the social worker is nearly always a welcome visitor, even if the parent is only bent upon explaining that there is no problem, and that the child would never have been referred to the clinic but for the malice of some third person. Such is rarely the case however; usually parents are only too well aware of their children's problems, though bewildered as to the possible causes. They are then quick to realise that a child's difficulties cannot be understood without the fullest possible knowledge of the circumstances of his life, including the sort of home in which he lives. Often the social worker is greeted with some such words as "I thought you would want to come and see his home. . . . I'd like you to see that he's never wanted for anything. . . . You can see for your-

self." Here though one can detect a certain defensiveness in the attitude, and the emphasis is entirely on material things, there is an excellent basis for discussion. Sometimes the mother will go further and call in witnesses to support her. If she has persuaded the father, grandmother or other relations to be present, this is usually an advantage, as it throws valuable light on the relations of the various members of the family towards one another as well as multiplying the sources of information. Sometimes, however, it cuts both ways. In one case the mother, grandmother and unmanageable small girl of six were all there to receive the visitor. Grandmother began by admonishing the child, "Now you keep quiet or I'll smack you, and I'll smack your mother too if she interrupts." This, whilst not helping to elicit information from the mother, provided an important clue to the family situation, which was further revealed by the mother's complacent remark as she let the visitor out, "You can see I have no control over Pamela. I am nothing but a child in the house myself." On another occasion, this time of a visit in a very poor district, every door in the street stood open, and most of the inhabitants seemed to be assembled in the crowded kitchen when the visitor arrived. It was of course quite impossible in the circumstances to obtain a coherent story from the mother, but the chorus of neighbours, with many dark looks and shakings of heads, was eager enough to fill in the gaps. "It's true, she was born wicked." "I don't know how her mother puts up with her, if she'd been mine I'd have had her put away." "I shouldn't be surprised if she's in my house now, looking for what she can pick up." Such was the burden of their remarks, and perhaps they provided as useful a picture as any of the background of melodrama against which, in this romance-starved neighbourhood, a small girl of seven was being driven to play the part of villain.

More often than not, however, it is the mother alone who receives the social worker, and a long chat by the kitchen

fire is the chief source of information. Be that as it may, the attitude of the social worker at this first visit remains the same. At all costs she must avoid giving the impression of being an interfering busybody, and this is much more than a matter of technique, for the danger cannot arise if she approaches the situation in the right spirit. After all, she really *has* come to learn and not to criticise; not even, at this stage, to help. She will therefore be in a receptive frame of mind, holding her more critical faculties in abeyance. This does not mean that she can be mentally half asleep; on the contrary, to be creatively receptive she must be alert to catch the significance of every phrase, with all her perceptions sharpened to take in details of the psychological and material environment. It *does* mean that her approach at this first visit must be more that of the artist than of the social reformer. She will then find, whatever the actual situation, whether the mother is alone or in company, busy or at leisure, friendly or antagonistic, that there is abundant material at hand to illuminate at least some aspect of the family situation. It may not be possible to compile anything like a complete home-surroundings report, but sometimes a telling fragment can prove just as useful, for she is primarily concerned in discovering the emotional relationships of the members of the family to one another, and particularly to the patient, and these may be shown in a single incident. The types of situation for which she will be on the look-out are described in Chapter Five.

An approach which is genuinely uncritical, as of one more willing to listen than to lay down the law, is somewhat unusual, and is quickly sensed by the parents, who are often encouraged thereby to reveal attitudes which they would normally be guarded enough to conceal. It is not uncommon in such circumstances for a mother to confess even to murderous impulses towards her child, or to irrational fears and superstitions which she has hitherto carefully kept to herself. In any event she will allow herself to speak with

the greatest freedom of which she is capable. So far as possible the social worker allows her to tell her story in her own way, and avoids anything in the nature of an inquisition. With a little experience it is not difficult to get most of the information required without appearing to ask many questions. Often indeed, if skilfully drawn out, parents will reveal more in this way at a first visit than in many subsequent interviews, for later on, when the social worker has perforce to adopt a more active role, they are apt, for a time at least, to be much more on the defensive.

It follows that even clearly harmful practices should not at this stage meet with explicit criticism. Thus if a mother admits that she always smacks her child for bed-wetting, it is enough to ask " Do you find it does any good ? " to which she will almost certainly reply " Not a bit of good ", adding perhaps " I think he's getting worse " or " It only makes him defiant ". The matter can be left there for the time being. If the mother is incapable of drawing her own conclusions, the social worker will be in a much stronger position to convince her of the wisdom of changing her methods after the child has been examined at the clinic, for she will then have the backing of the psychiatrist, who will be able to throw light on that particular child's reaction to the treatment he has been in the habit of receiving. In addition she will have avoided the risk of antagonising the mother before she has even entered the clinic, or of putting her so much on her guard that other equally dubious practices are carefully concealed.

A wise restraint at the first visit sometimes brings a more positive reward, for the mother may be almost conscious, though unwilling to admit it even to herself, that she is at least partly responsible for her child's problem. In this case it may be something of a shock to her to find someone whom she regards as an expert, willing to discuss the problem exhaustively without blaming her in any way. . . . It may set her thinking, so that she arrives at the clinic in a frame

of mind in which, convinced of the desire of the staff to help her, she is quite able to accept advice, and even to offer constructive criticism of her own former attitudes. Thus the mother mentioned above, who was complacently putting herself on a level with her child whilst all authority was usurped by the dominating grandmother, arrived at the clinic with the following words : " I've been thinking it over since your visit. You saw how my mother treats me. Well I've come to the conclusion that I've been too much of a baby myself to bring up a child properly. No wonder Pamela doesn't respect me." She almost asked to be told that the remedy was in her own hands, and after the psychiatrist had explained that there was nothing wrong with the child except a certain precocious toughness in exploiting the situation, she went home satisfied. A few weeks later we had a letter in which she said she was getting together a home of her own for her husband and children and now felt quite sure she could manage Pamela without any further assistance.

Note-taking on a home visit is nearly always inadvisable. It destroys the friendly, informal atmosphere, interrupts the flow of conversation, and may arouse the parents' suspicions. If it should be necessary to make a note of any particular fact, such as the name and address of the family physician, it should be done quite openly with the purpose explained. But as a rule such records can be more conveniently made in the clinic at a later stage.

Another thing which the prudent social worker avoids is conversation with neighbours. Of course any betrayal of confidence by deliberately encouraging gossip is out of the question, and would never occur to a responsible social worker. Sometimes, however, it is tempting to listen to an unsolicited opinion on a case. Perhaps there is no one at home in the house visited, and the sound of knocking brings a neighbour to her door, who procedes to volunteer all kinds of information about the absent family, sometimes of a

scandalous nature. In such a case the social worker should on no account reveal her identity or business, and if she is wise she will cut short the story, however interesting, for such a person is seldom discreet, and may later give such an account of the conversation as will destroy at the outset any chance of co-operation from the parents, even if it does no further harm.

Often the experienced psychiatric social worker can get quite a sound impression of the mental atmosphere before she even enters the house. Though she does not go primarily to gather detailed information about the material surroundings of the patient, such details often give the clue to mental attitudes, and, more or less unconsciously perceived and evaluated, form the basis of those 'hunches' with which she sometimes finds herself already equipped as she stands upon the doorstep. They may of course be mistaken, but more often they are confirmed In one house the gate off its hinges, the neglected garden and general air of decay faithfully expresses the atmosphere of depression and apathy within. In another, the face peeping between closed curtains before the bolts are withdrawn and the door cautiously opened a few inches, the sinister shut-in appearance of the house, indicates more serious mental disorder. On the other hand, there is the house whose brass knocker is always the brightest in the street, whose windows gleam in front of spotless white curtains, and whose doorstep looks as though it had never been walked upon. The mother here is an obsessional neurotic, who can rest only when there is nothing left to be done, which means of course, never. Her aggressive insistence on outshining her neighbours has earned her the title of 'Lady X'. The home is not a happy one for her little boy, who is not allowed to mix with 'common' children nor even to play freely indoors for fear he should make a mess of things. It is not surprising that he is a timid, inhibited child.

Much more, of course, can be learned inside the house,

for here, making allowances for different social customs, there is bound to be a considerable expression of individuality. A woman who does not care for her home cannot conceal the fact, whereas one who does often succeeds in making it surprisingly symbolic of her personality. For example, on one visit the home was found lavishly decorated with artificial flowers, paper festoons and a variety of statuettes, representing pierrots, ballet dancers and nudes. The children were beautifully dressed, but were sent out to buy their own dinner, which consisted of a pennyworth of chips each. The mother was a woman with plenty of vitality and spirit, but self-centred and insincere, and when it came to the point little inclined to put herself out for the welfare of the children, in spite of protestations to the contrary. A devotion to the spurious and showy was manifest in every aspect of her life, down to the minutest household arrangements.

A well-cared-for garden, flowers growing indoors and pets of all kinds if normally treated, can usually be regarded as hopeful signs. They are seldom found in a home where mental health is entirely lacking, for where all surplus energy is absorbed in neurotic conflict, there is none to spare for other forms of life for which no one is obliged to undertake responsibility. Other hobbies and interests, particularly those of a social nature, can equally well indicate, and help to sustain, the mental health of those who pursue them; but all social workers will agree that such outside interests are too seldom found among the mothers with whom they come in contact. The War has made some difference in this respect, and there is today, even among those whose duties keep them mainly at home, far more sense of social responsibility and of the pleasures of co-operative effort than was formerly to be found.

The relationship in which a family stands with its immediate neighbours is often a useful indication of the general social attitude of its members, and can best be assessed during a home visit. Some apparently innocent observation

or casual question about the type of people living round about sometimes evokes a revealing answer. The reply so often met with " I never mix with neighbours " or " I am not one for neighbouring " is not to be taken too literally. It is probably little more than a conventional repudiation of the idleness and gossip of the slum street with the ever-open doors, by those who have seen too much of such life. Other comments may be more illuminating. Thus one woman — it was the ' Lady X ' referred to above — said : " They're a lazy lot round here. I'm always out by six o'clock, banging the lid on my dustbin. I hope it wakes the whole street, it'll show them I'm not one to lie abed if they are," thus revealing her aggressive independence. Sometimes, on the other hand, a lack of security is shown by an undue dependence on the good opinion of neighbours. One woman, in spite of her own convictions, refused to tell her children anything about sex, because, as she said, " None of the neighbours believe in children knowing these things. They ought to be taught in school, then no one could blame the parents." But friendly and harmonious relations with neighbours are fortunately not uncommon, and in these cases the prognosis is good, at least so far as the parents are concerned, for it is probable that they will be equally friendly and co-operative in their relations with the clinic staff, and will be adaptable enough to act upon the advice given.

If the external features of home life, and how these can be interpreted, have here been dwelt upon, it is not so much because they are of paramount importance in diagnosis, as because they serve to illuminate an important aspect of the child's life, which must always remain obscure without a home visit ; and the home visit, if made at all, is peculiarly the province of the social worker. If it is not possible, the social worker, or another member of the staff, can of course obtain valuable information about the family situation through interviews with the parents and child in the clinic, but much will have to be inferred, and much will remain

obscure that could have been made graphically clear if these same people could have been seen in their natural setting, the home, a miniature world which is consciously and unconsciously moulded by the family to give symbolic expression to its collective inner life.

Often it is advisable to visit the school also before the child comes up for examination; if, for example, he has been referred by his head teacher without an adequate report having been sent, or if, after visiting the home the social worker feels that the problem is one arising more out of school than home life. In any event, it is the custom in most clinics to ask for a written report from the head teacher on every referred child of school age. These reports are most valuable, giving as they do an objective view of the child in relation to others in his intellectual and social attainments. In a personal visit, however, the head teacher may in addition be able to throw light on the whole situation. Often he has known many members of the family, and even the parents themselves may have passed through his school. On one home visit it was suspected that the child in question was more backward than the mother admitted. She insisted that he could read a little, and was " pretty smart " in other ways. A visit to the school revealed that not only had they been unable to teach him even his letters, but that his mother had herself left school unable to read or write. True, he was " pretty smart ", but only at pilfering. Examination at the clinic proved him to be a feeble-minded boy, compensating for lack of success in school by successful lawlessness outside. In addition, his relationship with his mother was such that he was unwilling to exert himself to master a subject of which she was quite happily ignorant. If there is any friction between home and school, it is usually best to postpone the school visit until the parents' consent can be willingly obtained, and to be content in the meantime with a formal written report. Where for any reason the parents particularly do not wish the school to know of the problem, which may

be a purely personal one such as enuresis, their wishes must of course be respected.

To sum up, then, as a result of her preliminary visit to the home, and perhaps also to the school, the social worker should be able to present to the other members of the team as her contribution towards diagnosis a report embodying the following features :

1. A general account of the child and his problem as seen by the parents, and also perhaps by his head teacher.
2. A description of the family as a whole, with some account of the personalities, occupations and histories of both parents, and of any brothers and sisters.
3. A picture of the home in its material aspects, and in relation to the outside world.

Emphasis must be laid on the possible bearing of any information gained upon the problem for which the child has been referred, but any attempt at a complete interpretation at this stage would be premature.

The information contained in a preliminary report is often very incomplete, and it is much better that it should be so than that the social worker should risk spoiling the relationship between herself and the parents ; much better no report than a parent who arrives at the clinic resentful and suspicious of prying, or who possibly decides not to come at all. A report, however interesting, is of little practical use if it has been obtained at the expense of jeopardising further treatment.

Another thing which may limit the value of a social worker's report is a lack of skill in presentation. No matter what her powers of observation and of psychological understanding, in this aspect of her work she is the eyes and ears of the other members of the staff, and unless she is able to convey to them adequately what she herself has seen and understood, her work will be of little value. This means, in a busy clinic where the time for discussion is limited, that she

must cultivate the art of concise, graphic description, concentrating always on essentials, and limiting her use of the wealth of detail at her disposal to the illustration of salient points. Here again to be effective the social worker needs to be something of an artist.

Chapter Eight

Methods of Examination (2)

THE INTELLIGENCE TEST

THE psychologist in the diagnostic interview with the child has first to obtain an accurate assessment of his intelligence by means of intelligence tests. Secondly, she has to discover as much as possible about the child's mental make-up from his behaviour in the test situation, if possible linking up her findings with the known facts about the child.

As a psychological interview is usually the child's first introduction to the child guidance clinic, it is of the utmost importance to allay any anxiety which may have arisen in him. This is sometimes caused by a fear of all strangers and strange places, sometimes by previous threats from parents, and often from the child's own feeling of guilt engendered by the symptom for which he is attending the clinic. For example, the delinquent child may be conscious of his thefts, the enuretic of his bed-wetting, the school problem of his failure to do school work. In practice it is found that the friendly but matter-of-fact atmosphere of the test situation itself is in most cases effective in allaying such anxiety, and that no more direct approaches to it need to be made.

At the beginning of the test interview the child can be put at his ease by a friendly question about some familiar and safe topic. The art of establishing a quick relationship has to be cultivated and the technique varied according to the child. It is usually only with children of pre-school age that it is necessary to allow the parent to remain in the room. With older children the presence of another person during the test is a distracting influence, especially if that person is one normally in authority over the child and for whom a certain

reputation has to be maintained. With the pre-school children it is sometimes possible to compromise by allowing the parent to come in at first and either go out as the child becomes accustomed to the examiner, or to sit in a far corner of the room. It is essential that if the mother or any other person is present during the test she should remain completely silent and be as much part of the furniture as possible. For a possibly over-anxious parent this is not an easy task.

A wide experience of the administering of intelligence tests gives the psychologist a clear conception of the quality she is measuring; but it is not always easy to explain this to parents. When explanation is called for, an effort is made to include the idea of potentiality as opposed to achievement, educability as opposed to learning, and the ability to respond to new situations as opposed to the possession of elaborate stock responses to complicated though familiar situations. It is explained that the intelligence test is designed to measure what the child *can* learn, as opposed to what he *has* learnt.

The psychologist's first aim before beginning the test is to create an atmosphere in which the child feels entirely confident and at home. It is essential that this is achieved not only before the test is actually begun, but that it is maintained throughout the test. The first approach to each child must essentially be an individual one, and the opening remarks need to be chosen according to the nature of the child in question. The degree of skill in putting the child at his ease in the beginning is an important factor in the obtaining of an accurate assessment of intelligence. The examiner needs first and foremost to be a human being with a genuine clinical interest in the child, capable of making him feel that she is friendly towards him. This is usually most easily done by casual remarks rather than by a more positive approach. An adult who accepts him naturally and with confidence is more likely to be considered than one who goes out of her way to make overtures.

As children referred to child guidance clinics are prac-

tically without exception maladjusted to their environment, the above precautions are of even more importance in the testing of children in the clinic than in the testing of the normal child in the school. Similarly, the testing of the maladjusted child presents difficulties not normally encountered in the testing of the children who are normally well adjusted. It is, for example, more difficult to be sure that the child's best efforts are being enlisted. For this reason psychologists wishing to work in child guidance clinics should first have had adequate experience of using intelligence tests on normal children.

The scores of a test of intelligence are for purposes of comparison most conveniently expressed in terms of mental age. Mental age is the average standard reached by a random sample of children of that particular age. Where a child can only reach a mental standard below his actual age he is said to be sub-normal in intelligence; where he is able to reach a mental standard above his actual age he is said to be super-normal. Where the mental age is exactly normal or average it coincides exactly with the actual chronological age. Thus, for example, a normally intelligent child of eight years would have a mental age of eight years, a super-normal child of eight might have a mental age of nine, ten or eleven, and a sub-normal child of eight a mental age of five, six or seven, according to the degree of super- or sub-normality.

To give this measurement a wider value the mental age of the child is usually expressed as a relationship to actual age. This relationship expressed as a percentage is known as the intelligence quotient (*I.Q.*)

$$I.Q. = \frac{M.A.\ \text{(mental age)}}{C.A.\ \text{(chronological age)}} \times 100$$

It is obvious from this formula that where the mental age is above the chronological age the *I.Q.* is more than 100, and

where it is below the *I.Q.* is less than 100. It also follows that the difference between chronological age and mental age is significant in geometrical progression; that is, a difference of one year at five corresponds to a difference of two years at ten.

The distribution of intelligence for the whole population falls roughly on a normal curve showing a small proportion of very sub-normal, a very small proportion of very super-normal, and an increasing number of the less extreme to the large mass of those with average normal intelligence which form the bulk of the population. Approximately 50 per cent of the *I.Q.*'s of a random sample of people would fall between 95 and 105, about 15 per cent between 75 and 95 and between 105 and 125, and about 10 per cent below 75 and above 125. It is important to remember in this connection that the social, moral, ethical standards and demands of the world are, generally speaking, suited to the average group, because these standards are made by, and for, this group. Children falling above or below the general average may therefore be faced with the peculiar problem of fitting into a world too simple or struggling to keep up with a world too difficult.

The assumption behind this assessment and classification is that there is a constant speed of intellectual development for each individual and that this varies between individuals, being more rapid for the super-normally intelligent and less rapid for the sub-normally intelligent. This is, in fact, borne out in general experience; the bright child develops into a bright adult, the dull child into a dull adult. Further evidence is provided by the giving of intelligence tests to the same set of children over a number of years. *I.Q.*'s are found to remain approximately constant and the order of merit in the tests approximately the same.

The reliability of an *I.Q.* depends first on the reliability of the test; secondly, on the requisite conditions being maintained during the administration of the test. It is not within the scope of this chapter to discuss the reliability of the

various intelligence scales. It is usual in child guidance work to use a modification of the Binet-Simon Scale supported by performance tests when necessary. This scale is designed to test a range covering everything between a two-year and a superior adult level, thus covering all child guidance cases and making possible a direct comparison of *I.Q.*'s of different cases. It is designed further to test a wide variety of qualities and is non-verbal in the lower age-levels. Verbal tests in the upper levels are satisfactory because the ability for conceptual thought, which is part of what is being measured, is normally expressed in verbal terms.

The Binet Scale has the advantage of being more than a method of assessing intelligence — it is, as it were, a standardised interview, and it has the advantage of being consistently interesting both to the candidate and the examiner. Progress in the tests arranged in age-scales is easy to follow, the significances of successes and failures can be grasped as the test proceeds, giving clues not only to intelligence-level but also to character formation.

The importance of maintaining standardised conditions in the administration of the test can scarcely be over-emphasised. The result can only be valid if, first, the standard procedures are followed; secondly, the child is working to its maximum level in an encouraging atmosphere; and, thirdly, if the responses of the child are correctly scored. All these three conditions are essential. The achievement of the ideal standard procedure makes possible a detailed observation of the subject's behaviour under controlled conditions, in addition to the measurement of his intelligence.

The most up-to-date revision of the Binet Scale at present is the Terman-Merrill. This has two parallel scales, *L.* and *M.*, differing in material content but similar in difficulty and range. Re-testing on an exactly similar scale, with the avoidance of any possible practice effect, is thus possible. Perhaps one of its most outstanding advantages is the ease

and objectivity of the scoring. The subjective element in evaluating the subject's response has been reduced to a minimum. Very exact instructions are given for the administration of each separate test in the scale, thus eliminating the risk of indirect help being given through a repetition of the instructions by the examiner in another form. This has been found to be an appreciable source of inaccuracy in intelligence testing. The desire of the examiner to see the child do his best necessarily must have strict limitations. Detailed test instructions are an invaluable help in avoiding this source of inaccuracy.

The more familiar the tester is with her material, the more she is at liberty to observe the minor fluctuations of the child's behaviour. From this she endeavours to make judgments on his general confidence, his degree of effort, his response to another person, as, for example, his degree of attention, and the alertness or sluggishness of his responses. In addition, the quality of the child's movements should be noticed, the degree of tenseness or freedom, and in particular any symptoms such as facial or bodily twitches, nail-biting, fidgeting, etc. The child is judged, therefore, on the evidence given by his observable bodily behaviour as well as by his actual replies in the intelligence test.

The experienced psychologist will develop various tricks for getting the maximum information from the test situation. In general, she gives praise and approval regardless of the child's success or failure. Praise is given generously but naturally. The child is kept in a condition of encouragement. This can be helped in many natural social ways as, for example, spontaneous comments of appreciation, or casual remarks suggested by the child's specific response.

It is a good rule always to begin a test in clinic work at a level well within the child's capacity as the initial tests act as shock absorbers, enabling the child to do his best and the examiner to obtain a general idea of his level. The child then gains confidence and is prepared to work his

hardest. In the Terman-Merrill scale the vocabulary test is useful for this purpose in children over eight as it begins at a simple level. For the younger children copying the circle or square will often provide a starting place. Although, as a rule, tests should be given in the order specified in the scale, with younger children in clinic work it may be found necessary to modify this order according to the child's whim at a particular moment, remembering that his maximum effort is an essential criterion obtained only through his co-operation. For example, he may be prepared to do something concrete and not be prepared to answer further questions. With difficult children opportunities like this must be grasped.

The length of time that the test takes to administer varies with the speed of the child's responses. It is seldom less than half an hour and should not be more than an hour at the most. With children under seven, half an hour is usually the maximum time they are capable of giving of their best. Familiarity with test material, in addition to giving the psychologist more confidence, has the advantage of reducing the total test time and thus lessening the strain on the child. An orderly arrangement of test material is a help in this respect, but this should never be so orderly as to destroy the naturalness of the interview. The child should feel not that this is a series of questions the examiner is asking a number of children, including himself under these particular conditions, but that this is a private and personal interview between him and the examiner in which his best effort must be maintained. In this respect the individual intelligence test differs from the group test as given in classes, and this is one reason why its results are more reliable.

In practice in child guidance clinics the psychologist may find herself obliged to test either in a small room little bigger than a cupboard or in a large room nearly as big as a church. The ideal size of room for testing is something fairly small and intimate with not too many distracting factors and

essentially giving the impression of seclusion and privacy. As in all work with children, when their best efforts are required a cheerfulness of decoration and atmosphere has an advantage and should always be aimed at. Similarly, an easeful position for the examiner, testing possibly all day, repays well the possible initial extra cost in furnishing. It is the degree of ease of the interview that enables the psychologist incidentally to gain information from the child on his general attitude to his problems. Once confidence has been gained there is usually no further difficulty and the examiner can afford to expend part of her energy in watching the child's reactions in addition to the administration of the test. In particular, she can observe the child's responses to individual test questions.

It is possible to gain in this way information about the child's character, in addition to his general attitude to the test situation. Some may show their unrest by suspicion that every question is a pitfall. Some give examples which disclose their own personal problems, giving a clue to underlying worries. Tests which are more particularly diagnostic of personal attitudes are those involving social comprehension. Some children take a highly moral stand in their replies, others are more detached. Some give the reply in the first or second person, others keep to the more impersonal third. An example of a reply indicative of the child's character was given to the question for seven-year-olds. " What is the thing for you to do if another girl hits you without meaning to do ? " The answer after some thought was : " Hit her back without meaning to." The child giving the answer was a half-caste, alert to stand up for herself in a society where she knew the moral code but did not feel a part of it. Similarly a child's responses to the meanings of abstract words and later to the meanings of proverbs may often give an indication of his attitudes to his own life's problems.

The psychologist also gains information whenever possible

from the child on his general attitude to his difficulties. This is best done at the end of the test interview in order to avoid any possible complication of the test score; also after a period of answering perfectly matter-of-fact questions the child will often just as automatically answer a question put to him regarding his attitude to his teacher, his school friends, his mother and other members of his family. Sometimes an opportunity arises during the test for such a question arising out of the child's particular response. In order to gain the maximum of information it is well to take these opportunities as they come.

The psychologist's report should include a description of the child's attitude to the test situation, whether he enjoys being tested or resents it, whether his responses are quick or slow, whether he seems to be working right up to his intelligence level or is keeping well within his powers. This will include in particular an assessment of his attitude to failure. Children vary in this from a fear of failure which is so great that it prevents any attempt being made to answer questions where there is the slightest doubt, to a natural acceptance of their limitations. The latter is more usual in the confident child, whereas it is not unusual to find a child of low intelligence putting the blame on someone else. "I haven't been taught that at school." Such children will go to great lengths to evade difficulty rather than face it, often making random guesses rather than admitting that they do not know. They may be characterised by a positive desire for approval or a mere negative desire to avoid disapproval. Others seem to be without any self-criticism.

The report should always include a description of the child's social poise and physical movements. The well-poised child answers the questions directly, usually moves with co-ordination and purpose and may be said to be in control of the situation. The child without poise often makes jerky haphazard movements ill-equipped for their purpose or often with no obvious purpose, except the relief of bodily

tension. Such are the children who continually fidget with their hands, who have bodily tics or nail-bite or who are muscularly rigid.

Characteristics of speech should also be noted, whether the speech is fluid or halting; in particular, any speech difficulty such as hesitancy, or stammer, lisps or inability to say certain sounds. The specific subjects about which the child stammers should always be noted and, in addition, his attitude to his stammering.

In reporting on the test any unusual scatter in the test score should be noted, especially if this in any way indicates that the true *I.Q.* might be higher than is shown. The reason for this should be given. For example, a note should be made if an otherwise intelligent child fails consistently on the rote memory tests for years well below his average mental age and has in the test shown an inability for sustained attention or real effort. Conversely, where a young child's *I.Q.* is brought up by marked success in questions involving school-learning such as numbers, which he does in ages well above his average mental age, this may be an indication of some over-pressing.

When the psychologist has opportunity to encourage the child to talk about his feelings and difficulties outside the test situation especial note should be made of his attitudes to his symptoms or delinquencies. Some children show insight into their motives, as, for example, the truant of low intelligence who admittedly evades school because he does not like being a " bad scholar ". Similarly, the child may know why he steals : " I steal when my Dad won't let me go out to play " ; he recognises the motive of revenge. Some are fatalistic, taking no personal responsibility : " Mother says it's been going on since I was a baby." Others are plausible, giving fictitious reasons, often blaming others always having an answer. Others are obviously living entirely in a phantasy life relating all their behaviour to phantasy ideals rather than to reality.

Methods of Examination (2)

The child's attitude to the examiner is often of diagnostic value. In particular this is so in the absence of real contact in the psychotic, the often fierce truculence of the epileptic and the attention-seeking tricks of the hysteric.

Some children show a real fear of being tested because they may be found 'barmy'. This is sometimes evident in the child who has a parent in a mental hospital, or mentally deficient, who is trying hard to conceal his deficiency, and has at school been called 'daft'.

It is usually possible to include in the report some indication of degree of neurosis, whether treatment is indicated, and the likelihood of treatment being successful. An assessment of the child's desire for recovery is helpful in this connection.

The formulation of the psychologist's report should bear in mind the person for whom it is being written. Where the report is purely intra-clinic all the spontaneous remarks of the child can be noted down to aid the psychiatrist in her interview. Where, however, the report is being made for a teacher or a medical officer not on the clinic staff, more reticence must necessarily be observed. Although the first task of the psychologist is an accurate assessment of the child's intelligence, which involves the use of the skilled technique of testing, no psychologist's report on an interview at the clinic is complete without some assessment of the child's attitudes and character formation in addition to assessment of his intelligence.

Chapter Nine

Methods of Examination (3)

THE PSYCHIATRIST'S INTERVIEW

In considering this part of the work of the clinic it is important to stress the principle that we are concerned with the child as a whole and that only by making investigation as complete as possible, and studying every aspect of the problem, can we hope to minimise mistakes. For this reason it should be the regular practice to do as complete a physical examination as possible, in order to try to be sure that one is not treating by psychological means a complaint which has an organic basis.

Some obvious cases needing such careful differentiation spring to mind; one child was sent as a behaviour problem. She was described as irritable, easily upset and fidgety. On physical examination she had obvious signs of a rheumatic heart, and when the mother was questioned about this, it was found that the child complained at times of 'growing pains' and had been noticed to be unusually clumsy. The case was referred to hospital, where the diagnosis of chorea was confirmed. Subsequent investigation proved that when the chorea cleared up the behaviour difficulties had also disappeared. The fact that it is much commoner to have cases said to have chorea which prove to be functional ties does not lessen the value of physical examination.

Another case referred for difficult behaviour and enuresis showed on examination unmistakable signs of an organic nervous lesion; and, referred to a neuro-surgeon, was diagnosed as having a cerebellar tumour, which was afterwards successfully removed.

Quite apart from this fundamental reason for such an

examination two others are worthy of mention. First, there is the question of the parents. It is often difficult to help parents to understand the nature of clinic work in the first instance, and a physical examination on which a definite report can be given is often a help both to reassure them where they have been anxious about some physical symptom, and also to give them confidence in the completeness of the examination. To win the support and co-operation of parents is an extremely important point if they are to be helped so to readjust their handling of the child that he, in his turn, will be given the possibility of normal development; and this can often be done by admitting parents to the physical examination, something of which they are already cognisant, and then using that examination as a measure of how thorough your enquiry is, and so leading on to other sides of the child's make-up, by pointing out observations noted of his behaviour during the examination, his shyness, anxiety, restlessness, negativism and so on.

Finally, these observations themselves are of great value. Symptoms will sometimes show then, which might pass unnoticed in a play interview or a talk; and apart from this, the child's behaviour and conversation may be almost diagnostic. One girl of thirteen, referred for refusing to go to school, said suddenly, "You don't think I'll die", and later, with complacency, "Yes, I have got a bad heart." She was obviously enjoying the whole idea of being ill, and in this had the support of her mother. Another small boy yielded with bad grace until it became a question of allowing his genitals to be seen, when he fought wildly and could not be induced for a long time to calm down, in spite of a promise given not to examine them against his will. Two important clues were revealed here, his fear, psychologically determined, of such an examination, and his fundamental insecurity which could not trust the promise of a grown-up. Later experience of the family showed how natural was this second feeling.

This point brings us to another question. Are there any circumstances which justify the delaying of such an examination, or even of withholding it altogether? There appear to be some rare cases. First there are cases where there is no evidence of physical upset or where the child is already under ordinary medical treatment. Secondly, it sometimes happens that the child's fear of hospitals and doctors is the main or at least an important feature of the case, and one must overcome this resistance and win his active co-operation rather than use force to carry out what will then inevitably be an unsatisfactory examination; and, thirdly, a group of cases, among which might be cited the child referred to above, where the child's interest is entirely centred on his physical difficulties, and it is desirable to try to re-orientate him. This is the most difficult group since one needs to be sure of one's ground.

Passing now to the psychiatric examination, we find the scene changes. For the physical examination it is sometimes good to have the parent present; for the psychiatric examination, on the other hand, it is never the best way and rarely desirable or even possible. The only possible justification for such a course is when the child cannot be separated from the parent, and the only way to get an interview at all is with the parent present. The parent should then be asked to be as quiet as possible and provided with a paper or invited to knit. Anxious parents are quite unable to be detached in this way, but some co-operate well and become, as it were, just another adjunct to the furniture of the room, but one that gives the child confidence by its familiarity.

In no case should a parent be admitted merely because he or she wishes it: this only occasionally presents difficulties. Although it is rare to find the parent who can completely accept the right of the child to a private interview, when its importance is explained it is unusual to meet with an open refusal. What is the purpose of this psychiatric interview? It is desired to obtain a picture of the child's emotional

development and adjustment. There are many difficulties in the way. It often happens that the child has not been told the reason for the visit or has even been told a deliberate lie. One child coming for sleep-walking was told she was coming because of her catarrh and her tonsils and chest would be examined. When parents have been so unwise it is usually possible, though time-consuming, to get round it; but other children are sometimes obviously puzzled. More difficult still are the occasions where the clinic has been used as a threat. The child has been told he will be "kept there" if he isn't good; one small boy, a delinquent, rushed twice down into the street because such a threat had been used, and needed to be repeatedly assured that the clinic had neither the right nor the means to keep him. It is sometimes worth while in such instances to call in the parent and explain to both him and the child that neither he nor the clinic, nor indeed anyone save the magistrate in Court has the power to keep the child in this sense.

The actual form of the interview depends of necessity on the age of the child, his capacities and the nature of the complaint. With small children, play is the natural method of approach. If it has been possible to establish friendly contact during a physical examination, it often happens that the child sees and remarks on some toy in which he is interested, indeed it may be difficult or impossible to persuade him to wait for it and important to persuade the parent not to interfere with his expressions of interest. This opportunity can always be utilised by saying that chance is coming to play with that and any other toys. Later this is followed up by an invitation to play coupled with the suggestion that we should let mother go and read her paper in the other room. Sometimes this latter suggestion is received doubtfully or with open fear, and one way of helping the child to accept the separation is to suggest that perhaps she will leave her bag or something else so that the child feels sure she cannot go and leave him. Occasionally it is necessary for the

child to see where she goes and to have the door open, or he may feel the necessity of reassuring himself by breaking off his play once or oftener to go and see in person that mother is still here. All this if of definite diagnostic value as a measure of the child's lack of security, and of the relationship between parent and child.

Once a child settles to play, his methods and freedom, his use of material and dexterity in handling it, his care of and anxiety for his clothes and hands, or on the other hand, his complete incapacity for using any kind of material, lack of concentration and consequent flitting from one toy to another may all be useful indications of the nature of his difficulty. Further details would be irrelevant here and will be found in the chapter on treatment.

With older children and even sometimes with the young ones who have been discouraged in play at home, this method does not work. One small child of seven who was shown the cupboard of toys remained a long time in front of it, then slowly selected a box of bricks and brought it back to the fire. She seated herself in a chair and spent the rest of the interview pulling the lid half open and then shutting it again. Later the mother reported that she had said she did not want to come again. " They expect me to play with toys like a baby." It was not surprising that she felt like this since the mother admitted that the child had nowhere to play but the drawing-room and she hated a mess. Her sofa cushions were of more importance to this woman than her child. In such cases other methods have to be devised, and a useful one is drawing. It is unusual to find that a child refuses to draw, though the kind of drawing produced will vary from really free phantasy to a most stereotyped and unimaginative design, or the child, having thought for some time, will sometimes say with evident relief, " I'll draw what we did in school this morning," and one recognises that he has withdrawn behind his defences.

Drawings, like play, may occasionally give a clear explana-

tion of a problem. A girl, for example, drew a tree at one side of the page, a house at the other, a girl by herself and with her face turned away between the two. This girl had been misbehaving since the father had left home and was unhappy with an unsympathetic mother. When asked about her drawing, and the tree by itself, she replied apparently irrelevantly. "Daddy lives in the country now." This encouraged the psychiatrist to say: "Then the little girl is lonely like you." She looked surprised, but did not deny the suggestion. The home shut against her probably represented her mother, but it appeared too soon to be wise to make a suggestion of this kind, so the matter was left.

The kind of active co-operation in talk which one hopes for in adults can rarely be achieved with children, but is occasionally a good method, and, however difficult, is usually the one of choice with adolescents. Even then one's approach is usually more active than with adults and much more encouragement and explanation are needed before the youngster will begin to talk at all freely. The question of whether to attack the actual problem directly or to try to get him talking about school, home, hobbies, or his future depends on the individual. Many of these older children have come unwillingly and knowing the reason and need some kind of reassurance to give them a start, others may be so resentful that they will not talk at all or become silent when the problem is broached. For all these children, and often for the younger ones too, quite clear explanation is needed if they are to understand at all what one is trying to do. Often their problems have been discussed in front of them and to the neighbours over and over again, or they have had to repeat the same story, usually untrue, to parent, policeman, magistrate in court, and perhaps teachers and others as well. It is most important to these youngsters to establish an atmosphere of confidence, and a direct explanation of the privacy of the interview is very valuable. Some children can accept the idea that their interview is private and that you do

not propose to repeat their remarks to anyone, and that it is for this reason that you have seen mother first and now excluded her. With others more freedom may be obtained by adding that you want to help them in their difficulties and that it is important to be frank and honest as, unless they tell you what is really true, you cannot help making mistakes. But children's confidences are so carelessly treated that it is unusual to get the idea fully accepted at first, and it only comes to be realised gradually in the course of treatment. Occasionally the child becomes more convinced by the psychiatrist actually asking permission to repeat something he has said. May I tell mother you said so and so? The look of astonishment that anyone should think it necessary to ask him any permission shows how little his private thoughts and wishes are usually respected.

In discussing the examination of the child we have passed over another part of the diagnostic interview, which, as already implied, usually actually comes first, namely the interview with the parent. The detail of this varies much from case to case, depending largely on what it has been possible for the social worker to get beforehand; but however detailed her report, and however close the understanding between psychiatrist and social worker, some personal contact with the parent is valuable. For one thing, such an interview gives a key to all subsequent handling of the child. A gesture, a chance remark, the dress or bearing of the parent, a difference in attitude of the child when she is present from when she is absent may, any of them, throw a spotlight on the nucleus of the situation. Moreover, there is the parent's point of view.

Labels have their uses, and the label 'doctor' is one which carries a great deal of weight with many people. The idea of the 'doctor' not hearing at first hand the parent's story is one which few can accept. Indeed it is often difficult afterwards to persuade a parent to stay out of the picture and she will sometimes compensate for what she thinks she has

lost by giving the social worker the same title.

As with the child, so with the parent, the first and most important thing is to estimate her. Is she really wanting help or merely on the defensive against anyone who might criticise her in relation to the child or criticise her child? Occasionally family or marital disagreements are entirely glossed over, only to be brought to light by the spontaneous remarks of the child later. The attitude of parents, especially of a mother to her whole family and to the child in question is also very important. Sometimes she may resent losing time from work in order to attend the clinic or complain that the other children or the father need her attention. One mother was sure that the psychiatrist sympathised with her need to go out and dance in the evening, even though she left behind a small boy, whose main symptoms were fears, including, as she well knew, fear of the dark. Another insists that she must carry on with her work as the Government was asking for people to "do munitions", and could not be helped to understand that it was no part of the policy of any wise Government to encourage a woman to work where this could be clearly shown to be harmful to the children. Usually such arguments are rationalisations, more or less unconscious, and indicate an unwillingness to deal with the home problems or a definite rejection of the child.

On the other hand, some parents are anxious for advice and to understand something of their own and the child's difficulties. They listen eagerly to explanations of the possible underlying causes and desires represented by the child's symptom, and the relief of finding that one does not regard pilfering in a child of seven as a sign of moral degradation, or masturbation in one of younger age as one of a vicious character, is of itself sometimes enough to change the parents' whole bearing to the case, and to start a better relationship which gradually adjusts the child's own development.

In the history that the parent can provide he may also

produce details which are of the first importance. There is the question of heredity. Is there any kind of instability in the family? It is well to avoid the actual question of definite breakdown; the disturbing question 'Has anyone ever been in a mental hospital?' is best left to the end of the family-history; but whereas mental illness is regarded as a stigma, 'nervousness' and being 'highly strung' are regarded often as marks of good breeding and are produced willingly enough.

Some indication of the reluctance to admit to a more serious illness may be shown by the reply of one woman who at first denied all suggestion of such illness and then said — "I forgot, my twin sister has been in a mental hospital for fifteen years." If a positive history is forthcoming it may be clear that the parent herself has been disturbed by this background, and attributes the child's own symptoms to it, the more so if such a background is on the other parent's side. Help may be given by explaining that inheritance of mental disease is not the clear-cut picture that the lay public learn to believe, and that environment can do much to help.

In the early history of the child we may find much to confirm what the intelligence-level suggests such as a delayed development in walking, talking and cleanly habits, or, later, in acquirement of the rudiments of schooling, which may indicate a slow development of the whole organic nervous system; and we may also find other things to explain either physical or psychological maldevelopment — a frankly unwanted pregnancy, or a child of the wrong sex, a difficult birth with subsequent conscious or unconscious rejection of the child, difficulties with early feeding and weaning and so on. Early illnesses and accidents may also be of importance occasionally as the actual cause of the symptoms, more frequently as embodying some psychological trauma, such as fear of an anaesthetic or removal to hospital, which produces a later reaction. It is common to find that such events in conjunction with illness of the mother, death of either parent or of a sibling, or the birth of another child,

have been responsible for the onset of the disturbance.

Following on this, the present habits and attitude of the child may give a further clue. Does he sleep and eat normally? The answer to this gives some indication of the parent's standards and understanding as, for example, where it was found that in the home of a small girl who had made a practice of sleeping out at night, six children of mixed ages and sexes slept together in two beds in one room. Or again a relatively educated and on the whole understanding parent, who had brought up her children together naturally and freely, felt that she was being criticised for this upbringing because an effort was made to get her to understand that at thirteen it was no longer wise or suitable for her daughter to share a bed with her brother aged ten. Restless, stormy sleep with talking and walking or open nightmare is always evidence of anxiety, while the child who lies awake for long hours is commonly making phantasies or masturbating.

Where parents are parted, as so often in war-time life, a child may be used as a substitute by the mother, who often will project her own desires for a mate on to the child. It is one of the most difficult matters to 'get across' as so frequently the adults' own sense of guilt is involved.

On the question of appetite, one finds evidence not only of food fads of the children, but frequently of the most unwise handling by the parents. Everything is given in to, until the child is completely master of the house. One such child, when eggs were rationed at three a month, was getting all the eggs of the family, with complete indifference to the well-being of the other children.

Habits of sleep and appetite lead naturally to the discussion of other habits, which may not have been thought important enough to mention, though sometimes they are the presenting symptom. These include such things as nail-biting, enuresis, masturbation, tics and so on. All of them at times are signs of an emotional upset, but it is curious how varying is the stress laid on them by parents. One

mother brought her boy of eleven for nail-biting; became very emotional in describing this habit, gave assurance that his finger nails were so bitten that he could not even tie his shoe laces — "I have to do it for him", a statement which proved to be entirely her phantasy — adding "He even bites his toe nails, doctor," of which there was no evidence whatever. But some, on the other hand, have never noticed this symptom, even when it is very obvious. This is true also of enuresis; at any rate it is regarded by some people as so commonplace and so much a family trait that the mother's only reaction is to list the various members of the family who have also been enuretic.

Masturbation is rarely regarded with complacency and usually results in dire threats, which may have the effect of producing intense anxiety and subsequent neurosis in adolescence or adult life. It is rare, indeed, to find a parent who knows, or can even accept, when it is explained, that this habit is an early evidence of sexual life, and not of a seriously degenerate personality. Some enquiry at this point into the amount of knowledge of sexual matters which has been made available to the child is important. The popular term in current use is the 'facts of life'. Many parents, unfortunately, still view with horror the idea of giving a child such information as he asks and when he asks, so that this important part of his development will unfold itself as naturally as any other part. Many parents just cannot bear the idea of their children having this knowledge and have little idea of how much a child observes. They are frankly incredulous if one suggests that for a child even of tender years to sleep in the parents' room is for him to have the opportunity, seldom missed, of witnessing their intimate relationships together. Yet the evidence from adult patients that this is so, and that the knowledge, because of the parents' attitude, becomes guilty knowledge and so traumatic is overwhelming. It is astonishing how the adults' own guilt and embarrassment contributes to this; one mother of a

thirteen-year-old boy who had been before the juvenile court for interfering with a little girl, protested that he was innocent of all knowledge of sexual matters, and she was unable to see that the very fact of the charge argued some knowledge. She refused to allow him to be enlightened further and finished by saying " It is difficult for the parents if the children know too much."

Finally, the child's social reactions, as well as the parents' ability to see the necessity for suitable social outlets, are important material. How does the child get on with people at home, his parents, his brothers and sisters ? In the first relationship, is there a decided preference for one parent or a particularly negative or dependent attitude ? It is not unusual for a mother to complain of a boy—" he isn't afraid of his father," as if it were desirable that such a feeling should exist between them. Evidence of mutual dependence, especially between mother and child, may be available, the child of seven or eight making no real effort to manage his dressing or undressing process himself, and the mother quite unable to leave him to do so. She prompts him also if one asks a question and frequently reminds him of his manners. Occasionally the matter goes further than this, one finds that the child is not encouraged to make his own friends and go out with them, but goes everywhere with mother, who remarks " I should be lonely with his Dad away." Jealousy, overt or unconscious, of brothers and sisters, is another trait which may appear in this part of the history-taking ; here parents often understand the difficulty and appreciate its naturalness when the child is ousted by a new-comer ; but they are apt to misinterpret the same thing where it is concealed under over-affectionate demonstrations, and even while admitting that the time of onset of difficulty and the birth of the baby were coincident. Nor are they able to see that a bullying attitude to younger children as a whole has often the same roots.

Outside the family, whether in school or with his friends,

a very different picture may present. He joins in with things at school, he has always friends who call for him or whom he goes to meet, he belongs to the Scouts or other kindred organisation and enjoys the good fellowship he meets there. Perhaps he is hindered in this sociability by the refusal of the parent to have other children in, or to allow him out after dark, and by their anxiety about wet feet or badly cooked meals if he goes to camp, and so he grows up with his sense of adventure and desire for companionship limited — moody and disgruntled. Naturally, all children are not like this, some are of the introverted solitary type, reading or indulging in solitary pursuits, and mixing poorly or not at all.

Further knowledge can be obtained by finding out what sort of companions the child chooses, whether older or younger, and whether he appears as leader among his friends or as their tool. The choice of companions may be determined by the child's own intellectual level, or by his desire to dominate or be dominated.

Such enquiries complete the story in the average case from the psychiatrist's point of view, the remainder of the picture being obtained by other members of the team.

THE CASE CONFERENCE

In the early days of child guidance work the case conference was much to the fore. Such conferences were not necessarily, nor indeed usually, an affair only between the members of the team, but much more public. Teachers, probation officers or others concerned with the case were invited and ideas and plans were pooled. Sometimes much more publicity was given, and a case was discussed by a team for an audience of all sorts of people interested in the new work and regardless of their qualifications or their discretion.

For this last practice there seems little to be said. "Indeed it would seem an impossible practice in the ordinary pro-

vincial town and one likely to get the clinic quickly tabooed. Most people regard all procedures with doctors as confidential matters; and far more so, those connected with behaviour disorders and mental functioning in general. There is still unfortunately a stigma attached to such disorders in the public mind; and while it is certainly important that everyone should learn to regard them in the same way as other illness, to make a public parade of them is no satisfactory way of doing this. Fortunately the practice seems to have died out, perhaps because it was found to be dangerous, and to do a great deal more in the way of attracting morbid curiosity than in stimulating real thought.

So far as the former type of conference is concerned, there seems less of it too, and it may be just as dangerous. It is often difficult to draw a true picture of a case without giving away secrets either of the child's story or of the family life. It is sadly common to find the former regarded as of little or no importance, and therefore the keeping of the confidence as unnecessary; yet, if once the child discovers that he has been given away, real co-operation is no longer to be obtained, nor indeed should it be expected. The adult faced with such a situation would change his doctor; since the child cannot do this, he has no alternative but to close his mouth.

A written report in all cases is far safer. Much can then be put in general terms which violates no one's privacy, where in the round-table conference details could be pressed for, and one would be regarded as 'unco-operative' if these were deliberately withheld.

Yet there is a type of conference which is of great value, and this is the conference between members of the team after the initial interview. Each sees the case from a different aspect, determined partly by the work she has done, and partly by her own personality, and the pooling of ideas between members of a team who really work as such and who are prepared to evolve a scheme for dealing with the

cases which embodies their combined efforts is of immense importance.

So too the interim conference as the work proceeds, though this is more commonly between the two of the team who actually are handling the case. It is important for the parent to feel that his views and information get to the ears of the person who is treating the child, just as it is important for the child to feel his confidence inviolate. Indeed, only so will either co-operate to the full; and this presupposes close co-operation between the workers with frequent exchange of views.

Without these types of conference, which may be very informal talks, team work can scarcely be said to exist, and the case is rather handled arbitrarily by one or other of the workers. They are sometimes difficult to achieve satisfactorily especially in clinics working for only a few hours a week, and this lack of possibility for frequent meeting and limited possibility of contacts is one of the great drawbacks of the one- or two-day-a-week clinic. Much more satisfactory work can be done where at least a large part of each week is devoted by the personnel to clinic work.

Chapter Ten

Treatment (1)

INDIVIDUAL THERAPY WITH THE CHILD

WE come now to the difficult question of how it is possible to deal with the problems outlined in earlier chapters, why it is usually necessary to do so by seeing children individually, and how it is that such disturbances cannot always be dealt with either by parents or teachers.

In this connection one finds that two questions are persistently asked. The first is: "How do you do anything by just playing with children?", and secondly: "Since that is all you do, why cannot I do just the same?"

In this chapter an attempt is made to outline first the principles underlying treatment by play, secondly the place and meaning of play in the child's life, and finally what is the difference between 'just playing' and play therapy. It will probably become clear that the technique of this kind of treatment is one that requires both skill and experience and that it is its very simplicity which is baffling, so that a mother once remarked, "Well, I have been in the room each time you have seen her, and you have done nothing so far as I can see but play with her, but I've been trying for months to do just what you have succeeded in doing, and I just don't understand how it works." It should be remarked that the mother had been in the room because the child was at that stage too afraid to come alone.

What are the principles which underlie psychological and particularly analytic methods of approach? They are based on the assumption that where our behaviour does not conform to the accepted social standards around us, and/or does not apparently contribute to our essential personal

needs, it is dictated to us by those parts of our mental make-up which lie outside our rational control. In all of us repressions occur; certain unacceptable impressions and emotions are pushed into the unconscious and there remain, struggling to find expression for themselves and using every opportunity of parallel situations to obtain such expression. It is these unconscious wishes and emotions which are inaccessible to control, that find their outlet whenever a channel is opened for them which they can use to release tension. But both the individual concerned and society recognise that the outburst of behaviour is in no real relation to the alleged and immediate cause, with the result that there may possibly be an immediate momentary satisfaction, which is followed by a sense of frustration, inferiority or remorse at what the person himself regards as childish behaviour. So the repression is repeated and no progress is made.

What has happened has been a complete repetition of the original situation, including the censure of it, though this now comes from his own criticism of himself instead of from outside. A concrete instance may serve to make this more clear. The *ticueur* referred to in Chapter Four continued to make her movements whenever she had cause to feel annoyed. She was still afraid to feel annoyed because she had never grown through her childish fear of a sadistic mother, but she was no longer aware of any feeling of annoyance; that had been repressed, so instead the symptom occurred. Afterwards she felt hurt, and inferior, but also and very securely that she could not help it, an interesting combination of what she had felt originally and her mother's attitude about the tics. Only when she began to feel normally annoyed about frustrations, and to find that it was quite safe to do so, did the tics begin to abate. We have therefore to try to secure some opening up which will expose the source of the tension, and so secure an adequate outflow of energy. We are faced here with the fact that difficult and painful though the situation may be in which the patient finds him-

self, it has been evolved as a solution to a worse one, and that therefore the parts of his personality originally concerned in the repression will still fight to maintain it.

Analysis, first conceived and initiated by Freud, is the method of treatment on which play therapy has since been based. Briefly analysis consists in inviting a patient to relax himself completely physically by reclining on a couch with as few distracting objects before him as possible, and then to put into words all the thoughts, phantasies and mental pictures which crop up into his mind. The analyst sits, also relaxed and free, in the background, out of sight, so that he also is no distraction to the free flow of the patient's thoughts. For this method to be a success the patient's active co-operation is essential, an unwilling patient will not be able to give the necessary material and will just play with the treatment, and the essential and basic rule on his side of the analysis is to try to put into words whatever comes into his head, no matter what its nature be, nor whether it be repugnant or apparently trivial.

This process has been labelled 'free association' and the principle behind it is that thoughts — like water — will tend to flow along previously used channels, where they are allowed freedom, and therefore will follow previously established courses. Naturally there will be obstructions, and it is the task of patient and analyst to remove these and recover again the main channel. This free association is the main line of analytic approach ; but it is supplemented by another, the examination of dreams.

In sleep many of the repressing forces are, as it were, off duty, and the repression finds it easier to gain some part of the expression which it needs; but, in order to do so, it needs to hide the material under a camouflage of phantasy and present it in parable form. This is the dream. Since it is fairy-like, no account need be taken of impossibilities of time or space, and so our conscious mind is hoodwinked on wakening, and is able to say as adults do to children's

phantasies, "What a lot of nonsense." Indeed the dream is the product of the child within us, the child expressing in phantasy his wishes and desires, in a way safe from adult perception and understanding. Nevertheless it is possible to hear the dreams of adults, to see the play of children, and to understand them both.

Naturally no adult analysis can stop at this. Analysis and synthesis must proceed hand-in-hand if a successful outcome is to be achieved, and it is not enough to remove the blocks from a particular channel of outlet, but also to see that the source of supply is free, and that the flow is directed so that it contributes the maximum to the main stream of life. To change the metaphor, where one of the horses in a team has fallen, and is holding up the progress of the team by its inertia and its occasional frightened impulsive and ineffective kicking, it is not enough to free it of its obstructing harness and set it on its feet, it must also learn to pull with the other members of the team if it is to contribute to the progress of the whole, and also if it is not to be liable again to fall. So with the emotions and drives which we have seen to be the cause of behaviour disorders and neurotic illness. They need to be freed first of all, but they need to move in order and harmony with the physical and intellectual, producing thereby an integrated whole, which is something more than an aggregation of parts.

Let us now turn to the question of play and see what the play of children consists in and how play is, or may be, related to this analytic process. Play is, in the first place, the main method of self-expression in children, and it is a method of expression through imitation, construction and destruction, and through the world of phantasy. We are apt to think of it as unimportant, whereas it is the most constructive factor in the child's life and therefore demands our full attention. Nor is the child's expressing of himself essentially different from that of the adult as we shall presently see, though his methods of doing so are parallel

rather than the same. In both cases, while we may distinguish different kinds of activity, as above in the different sorts of play, or in the work, conversation and recreation of adults, often more than one is present and clear distinctions are not possible.

First, then, what sort of interests are aroused and satisfied in a child's constructive play? There would seem to be the simple acquirement of skills, the skill of bodily and mental dexterity, whether in the use of words or hands or feet. It is like the learning of mathematics, the skill in playing with signs and symbols, of manipulating them to your constructive end; but it is also like the manual skill of the machine shop, and the engineering genius of using these two skills so as to design a working engine. So with the child's play, he acquires both the mental skill of knowing the plan of a house, the essential features which need to be there, the manual dexterity of manipulating the necessary bricks, but also the phantasy which enables him to build just the house which is the creation of his own mind; and it is this last aspect of play of which we can make use to discover difficulties which may have arisen; in the actual structure of his house, whether drawn on paper or made in bricks or 'Plasticine', in the parts omitted, those added on as an afterthought even more than in the regular outline of the ordinary childish construction.

Perhaps this may be seen more clearly by again referring to an adult parallel, that of creative work, of novel-writing or painting or sculpture. It is a common observation in the case of novels that an author tends to repeat his theme in various guises, and it is usually true that one of his works has outstanding merit. It rings truer to life. It is sometimes provable and always probable that this is so because it is a disguised autobiography — it is in fact his phantasy life or, alternatively, the facts are the facts of his life, the thoughts and feelings those which he wished and was unable to express. Moreover, this is true of the reader: we read and are keen about books and plays which either

satisfy a need in us, or which depict and elaborate our phantasies.

So in the play of children, the house drawn without door or without chimney, two objects which usually occupy first place in the child's conception, clearly suggests some block in the admission of such ideas to consciousness. A picture that comes to mind was of such a house. Outside it was a solitary little girl standing, and beyond, away on the other side of the picture, a tree and a railway line. The child who drew this was a girl whose father was away in the country on military duty, who did not get on happily with her mother and who was obviously lonely and unhappy. She was clearly feeling alone and shut out of the house where mother was, while thinking of father in the country, a railway journey away. There were no childish companions in this picture representing her feeling of loneliness (see Chapter Nine, p. 127).

A small and very timid boy persistently came and laid out a battle scene. Two armies, of lead soldiers, opposed one another, supplied with guns and aeroplanes, but no shot was ever fired; no aeroplane ever came into action, he never finished his lay-out in time to proceed to this; but quite clearly this was not just a matter of time, but of holding back from such a decisive step. There were many opposing forces in his life, but he was afraid of the aggressive feelings of hate and unable to give them freedom even in the phantasy of a game. One could repeat illustrations of this kind almost without limit, but enough has been said to show that if one observes closely there is a great deal more to be understood here than ' just play '.

How then can one apply and adjust the analytic technique described above to children's play? It is clear that some of the rules of analysis are impossible of enforcement or simply do not fit. It is useless to talk to a child about active co-operation, or about being late for a session as evidence of resistance. It is plainly impossible to discuss the association

between relaxation of mind and body and to suggest lying on a couch as ways of doing this. Nor is it possible to insist that a child shall speak out or even play out the thoughts and phantasies in his mind. One has to work in some ways very much at a disadvantage, and further one has to accept the fact that the question of criticism and that of co-operation resides not just in the child patient, but partly also in the accompanying parent, who may hold off because of some resistance in herself, coming up in her talks with the social worker, discussed in Chapter Twelve; or because of her jealousy of the *rapport* established between the child and therapist, or because she disapproves of an alteration in attitude or behaviour of the child. Two familiar accusations of this last group are these of "He's been such a cheeky boy since he came to see you," and "I don't want him to be told those things" — usually matters of sexual import.

Having considered all these difficulties, one might feel as if there were nothing left as if the treatment of the child might prove impossible, and indeed it is beset with thorns, of a different kind from those with which adult therapy is surrounded, but none the less awkward to negotiate. On the other hand it has also its compensations. On the whole, repressions are less established in children and their trust is easier to gain. The chasm between an intellectual acceptance of the doctor as a skilled and understanding person whose job is to treat and cure, and the unconscious emotional rejection of him as a critical condemning adult from whom all secrets must be carefully hidden, is less established; and although opposition may be fierce, it is usually nearer to, or actually in, consciousness and therefore easier to deal with. Naturally this is referring to younger children, the younger the easier. Of all ages the adolescent is the most difficult, since antagonism and distrust of the adult is one of the problems through which even the normal adolescent wades, and which is invariably intensified in any emotional disturbance.

The first and most essential qualification in the successful treatment of children is to have a real love for them. It is true in a sense of all sorts of medical treatment that the sympathy and understanding, the 'bedside' manner of the doctor is a matter of importance, but this is truer of psychological treatment and truest of all of the treatment of children. Unless one can convey to them this sense, their confidence will not be gained, nor will they be able to re-establish that sense of security which is the basis of all normal development.

The second essential is an atmosphere of freedom which permits the child so to feel free that he can express in the outward forms of play the inner phantasies of feeling. On the therapist's part, this means being able to convey to the child a sense of friendly detachment, a sympathy and understanding and willingness to take part on the one hand, and uncritical detachment which leaves him free to express what he wishes in the medium of his choice on the other. Let us make no mistake about it; cold detachment is read by the child as disapproval — he feels himself not free but isolated, a thing no child is yet able to tolerate; he will retire into his shell if he feels this; on the other hand, encouragement and stimulation, over-friendliness and over-protectiveness will tend to produce in him a dependence which is also the enemy of freedom. This is truly the horns of a dilemma and is complicated by the fact that the actual method of getting the child to realise the therapist's relationship with him will tend to vary with each case, and is a matter for an intuitive grasp of the personality and problem presented.

Simpler is the question of giving freedom in outward forms of play. So far as possible, a room where children are treated should be free of all restrictions. Nothing which is accessible should be forbidden. Toys should be available to suit different ages and different tastes, but elaborate toys are not necessary. It would be impossible to furnish a complete list, but it may be useful here to make suggestions of

things which are useful and those which one feels should be excluded.

First in the list comes sand and water, without which no play-room should be considered even moderately equipped. In line with this and more used by the older groups are plastic materials, such as 'Plasticine' and wax, and drawing and painting materials, of which perhaps the more desirable are large pots and brushes, or finger-painting equipment rather than the stereotyped paint-box or pencils. Among the next lot of materials are building bricks, either the ordinary box of bricks or blocks, or the full-size brick made of plywood or card and coloured to reality. What needs to be avoided here is the modern box of bricks with ready-made doors and windows, carrying suggestions and reducing to a minimum the possibility of free phantasy.

Then there are the toys representing real occupations — animals and people, farms and jungles, motor-cars and trains, dolls and household equipment. All elaborations should be avoided, but reality — the child's reality — should be helped. By this is meant, for example. that soldiers should wear khaki, and that uniforms and the more spectacular dress of former generations be left out of the picture or at any rate reduced. It is a fact that for most children such unfamiliar uniforms, even sometimes, the Scottish kilt, are immediately transferred to the enemy ranks. Dolls need to be able to be undressed and if possible a complete family should be represented. Of the things to be avoided are the elaborate bricks already mentioned, and Meccano sets, jig-saw puzzles and fully-equipped doll's houses. Such toys are in themselves too absorbing or permit only of more or less stereotyped reactions, both inimical to and protective against the development of the child's own phantasy.

Finally, a word about games. Some of the ordinary school-room games are valuable as a medium in which conversation is more natural to a child, where he is either afraid to play with material or feels himself to have grown beyond it. Some

also themselves give an inkling of the problem. An illustration of this was the case of a small boy who chose repeatedly to play ludo. He was the third in a family of four — a shy child, very insecure, intensely jealous of and hating the elder brothers, especially the eldest. When we played, he had first to invent rules. Instead of the usual method of starting with a six, we started with six of four, and throughout the game rules were invented to suit his play and enable him to win, including what was termed 'sliding in' at the end which enabled him to finish without the difficulty of waiting until he had thrown the right number. The experiment was tried of naming the pieces after the four brothers, and then the piece that was himself invariably won.

This patient brings us to the question of interpretation. Often with children very little is needed. In this child, for example, the difficulties, which included tempers and bed-wetting and an obvious falling-off in health together with the development of a tic whenever he started to go to school, and a tendency always to play alone, began to clear up with an explanation of just what he was doing in this game. It was pointed out to him first that he wanted to arrange the world so that he could win, and secondly that he wanted to win especially against his brothers and even to destroy the eldest one. This was followed by the open statement that his jealousy of his brothers was because of his mother, and that his desire to defeat them and get them out of the way was so that he could have her to himself. This was then further connected with not wanting to go to school so that he could be more with her. This in fact he achieved by this method, as he was much with her in those circumstances and she attempted to do something to replace the school work he was missing. He is at any rate now going to school, mixing with others and getting on quite well, he has ceased to be enuretic, and the mother feels that the relationship between her boys is more healthy than it was. But it is not always as easy as this, and the question

of when interpretations should be given and what sort of things should be said has given rise to much discussion within the ranks of therapists themselves.

It was noticed earlier on that the question of co-operation on the part of the child involves difficulties not present in the adult case, since the facts of attendance and non-attendance result in the main from different factors, and the responsibility for and to the treatment is different. Consequently, the importance of establishing a relationship of trust and understanding is of the first importance, and in most cases early interpretations are to be avoided, lest the child become frightened and antagonistic and the parent seize the opportunity for which quite often she is looking, of protecting the child against the therapist.

Secondly, it is probably almost always sufficient with a child to interpret quite simply, to verbalise exactly what it is he is doing in his play, without going more deeply into its symbolism. Thus, in the case quoted above, it appears to have been sufficient just to explain to him that he wanted mother to himself, and daddy and the brothers out of the way, a theme that was appearing in his behaviour and in his play, without going into deeper Freudian explanations and bringing to his verbal consciousness the sexual need behind this.

Sometimes fuller interpretation of this latter kind may be necessary, but if clinical improvement occur without it, it would seem more natural to allow the child's intuition to meet one's own and the truth to be accepted on this basis without verbalisation, as it is indeed in the growth of the normal child. One small child at her very first interview took a family of bears — father, mother and child — and put them to sleep together. She was a masturbator, a piece of behaviour which filled her mother with horror. With the mother present, the therapist remarked : " Yes, you would like to sleep next to Daddy, wouldn't you ? " For a moment she stared, and then replied, " Yes, look how cosy they are ".

Jealousy and hate of her mother became obvious in her relationship with the therapist. So far as the mother was concerned, she was very dependent, refusing for a long time to allow her out of the room; but as she grew more confident, she played with freedom and her phantasies became more easily expressed. She liked to play with 'Plasticine', and presently began to insist that the therapist should make things too. She invited her to make a giraffe and the therapist complied, but her standards of attainment in 'Plasticine' modelling are low, and the patient looked at it in scorn and said, "That's not a good giraffe" and proceeded to destroy it, and then to show just what she could do and to get the therapist to admit that her efforts in this way were definitely superior.

In a situation like this, the child is clearly expressing feelings and thoughts towards the adult which would not normally be allowed to be spoken. This child's play was arranged so that it produced a situation which gave her reason to express such thoughts and feelings. They were really directed against her mother, who always insisted on good manners and respect, and therefore could only find expression via the therapist who was prepared to tolerate and understand. This type of situation is called a transference.

Another interpretive method, occasionally useful, is a story-telling one, where the telling of a story is shared with the child, and what one feels to be the problem with which he is struggling is introduced and discussed on this level. A modification of this is verbalising in a story what the child appears to be playing in material, and this is more usually possible and works satisfactorily. It has been found that deeper Freudian interpretations are most often needed in children with either nightmares or open phobias, and that then sometimes methods of association can be tried, which lead one from the symbol to the original object.

But, it may be asked, what happens when improvement occurs, either without any interpretation or with such slight

and indefinite ones as have been outlined. It seems that we have enabled the child to perceive that we have understood what he is playing at, both in the figurative and literal sense; and that understanding, we have shared in and accepted his thought and experience, his desires and feelings, by being able to play out the game with him. In this way he has realised that we accept it all as right and natural and a safe thing to do, neither dangerous to him nor to us. We have neither criticised nor condemned, only where necessary we have explained. Now in the child who develops normally this is surely what must happen, and if we can make it happen in the specialised atmosphere of the clinic the cure is effected by the re-living in the proper atmosphere, through the previously undigested experience. We have been, in other words, the wise and understanding parent, we have accepted the fact that his thoughts and feelings are real and natural, we have not thought in terms of right and wrong. It is in the next stage that we must try too to help him build up a sense of social values and to realise the 'wrongness', of lines of conduct which are inimical to other people. This realisation will be at first on a purely practical and material level, helped by the facts that such behaviour can be shown not to pay and sometimes also to be just what he is complaining of on the part of adults towards him. In other words he must first learn that in order to keep his individuality and his freedom he must be prepared to accept some limitation of it, since he lives in a world where there are other people demanding like rights for themselves. It is from this premise that all our ultimate moral and social values spring; and what seems so often to be misunderstood is that we cannot start half-way up the ladder and expect the child to learn to be social before he has had time to establish himself as an individual, and that where we have seen him beginning to accept both these ideas we must ourselves respect his individuality if we wish him to accept his responsibility towards society.

Chapter Eleven

Treatment (2)

GROUP THERAPY OF CHILDREN

THE principle underlying the psychological treatment of children in groups is the same as that described for individual treatment in Chapter Ten. The child, by externalising his difficulties, is able to understand them, face them, and afterwards, with some help from the therapist, to deal with them. Provision is made for such externalisation on the child's own level of development and understanding. It is found for this purpose that an adequate supply of play material is desirable, including if possible a large sand tray, water, paints, clay or 'Plasticine,' a rocking-horse, tools for woodwork, dolls, and all the smaller toys representing animals, soldiers, and the people and objects of everyday life.

Treatment of children in groups has advantages from the purely administrative aspect, because the treatment waiting list, which is often long, can be reduced through more children being taken at a time. Also cases requiring to be treated immediately can sometimes be taken into an existing group, instead of waiting their turn for individual treatment. This chapter describes the possibilities and limitations of such group treatment in different types of case. Its aim is to show that such treatment while being used sometimes chiefly as a matter of expediency has an additional therapeutic value of its own. In some specific cases and in some stages of treatment improvement is more readily obtained in a group than by treating the case individually.

The development of a technique for group treatment is as yet in its infancy. In recent years there have been develop-

ments along these lines in the United States;[1] but in Great Britain, although in a number of clinics group treatment has been practised over a considerable period, only a small personnel have been working on it, and there is little detailed published material on their work. Furthermore, under the general term 'group treatment' very different approaches are included.

The 'play group' means the play of a number of children together, but with varying degrees of control and organisation. It varies from the most organised, which is the one united planned game led by the therapist, to the least organised where a number of children are free to join up in their play with one another, or to remain solitary, according to their wishes. In this second type of group the therapist remains much more apparently in the background, acting as a catalytic agent, and at the same time keeping the minimum of control.

The term 'group treatment' is also used to refer to a number of children in a room where each child chooses his own separate occupation and is specifically instructed to carry on with this regardless and independently of the others. This type of group, in that each child is essentially alone, is in the true sense of the term scarcely a group at all. It is largely a device for economy of the therapist's time and the consequent reduction of the treatment waiting list. Some therapists use this in addition to an individual session each week, as a means of getting through the treatment more quickly.

These three types of group, while all treating the child, are doing it by different methods and at different levels. In general it may be said that the greater the amount of systematised organisation in the group the further away is this treatment from that given to a child when taken individually.

[1] Reports on this work can be found in numbers of the *Journal of Orthopsychiatry*.

It may be argued that the first type of group which consists of systematised play has little place in the child guidance clinic, in that children who are sufficiently recovered to benefit from such a group are at a stage when they can more usefully join one of the established youth services, such as Boy Scouts, Girl Guides, boys' and girls' clubs, etc. The characteristic of the neurotic child is that until his neurosis is treated he is incapable of benefiting from such organisations because he remains too much shut in within himself. In the immediate post-therapeutic period, however, such groups within the clinic have a socialising function which helps the children to make the transition back to normal life. Sometimes even organised classes of eurythmics or some handwork may be run by the clinic for this purpose.

The second type of group, where children are free to play alone or to join up together at their wish, opens up new problems in technique. For such a group the question of suitable selection of children is important. An elasticity in the constitution of the group is essential, and for the purpose of elasticity, time either before or after the group session should be available for any child who may need more individual attention. In general, children in a group take longer to settle down and are working at a lower pitch, therefore they need a longer time than the half-hour which is often all that can be afforded for individual treatment. If such elasticity is achieved, children come and go from the group without disturbance to the others and with advantage to themselves, and new members can be introduced without disturbance. Similarly, old ones can return and are automatically accepted.

It is found best, before putting children into a group of this kind, to see them first alone for at least one session. The child then realises that he has a special relationship with the therapist and can be given some idea of the purpose for which he is attending the clinic. His understanding of the therapeutic situation should be similar to that attained in

individual treatment. To achieve this, in this first session there should be as much ventilation of his difficulties and as direct an approach to them as his condition will allow. The part played by the therapist after this initial understanding necessarily becomes more passive because there is necessarily less opportunity in a group for giving individual interpretations of the child's play. The therapist, however, should always keep before each child the purpose for which he is attending the clinic and in each session should appear conscious of him as a separate person with his own special problems. This may often be done by personal reference about other members of his family, and frequently opportunities arise to relate his attitudes to them to his behaviour in the group. Usually the child without much difficulty comes to express himself more and more freely both to the therapist and to certain other children with whom he plays.

Giving interpretations to individuals within the group is perhaps made easier by virtue of the fact that the children coming to child guidance clinics for treatment are neurotic and as such are interested in and worried by their own problems. To break in on play and talk about the wet bed or the stammer or the strain within the difficult home or school situation, does not seem unreasonable to them, because their symptoms are an expression of their problems and therefore all-important. It is not resented as such an interruption would be by a normal child.

Treatment in a group of this type must remain essentially individual in that the privacy of the child is respected. The degree of this privacy depends on the child's wishes; it is complete just in so far as he desires that it should be complete. At times, in fact, he may be perfectly open about his problems, but sometimes this openness is only used as a defence against more intimate discussions with the therapist and it must then be treated as such. The very little interest the children take in the reasons why the others are there gives further evidence of the neurotic's absorption in his own

problems to the exclusion of other people's. It is seldom that overt curiosity is shown, and when this does occur it is usually from a child who is comparatively well. Such children are sometimes taken into a group more because of peculiar difficulties in their present life situations than because of some real neurotic character development within themselves. Mentally ill children are tolerant of one another's peculiarities just as physically ill children are. This is in contrast to the attitudes of well children to the ill.

While the individual treatment of children works usually on the basis of a transference to the therapist, that is of the therapist providing for the child a person on whom he can work out his emotional difficulties, group treatment while using this individual transference, has in addition a transference situation between the child and the whole group. It seems that this in group treatment can take the place of the strongly possessive feelings the child has for the therapist in individual treatment. The freedom of atmosphere seems to enable children very quickly to know one another, and usually after the second session new members have gained a firm foothold and greet the others as old friends. This usually applies even to children who are normally solitary and timid. The group provides a situation where the neurotic child, in many instances for the first time, realises that there are other neurotic children feeling in the same way as he does himself, possibly having similar difficulties to himself, and this increases his confidence.

Further, the child in the group uses the other children to play out his difficulties by making them objects in his phantasy play. He may want, for example, a mother, father, brother, sister, doctor or nurse in his family or hospital game, an enemy brigand or cowboy in his adventures, a tiger to be shot at in his jungle, a groom to wait on him as he sits on the rocking horse, or phantasy children to teach and punish in his school. Sometimes to take up one of these roles will suit other members of the group and

will at the same time help them to fulfil their own phantasy needs. Sometimes such demands result in a clash of wills which for the neurotic child, used to sinking into himself at any difficulty, is in itself therapeutic. The periodic stand-up fights in a clinic play group may be one of its more refreshing aspects. This may happen when a child used to being left out at home or school is called in to be a fellow burglar or a fierce horseman. A role he might never have dared to play had it not been demanded of him by another, but one which in the playing gives him fulfilment. A girl living in a ' cottage home ' where she was only one among many used to play the part of the all-giving, all-important Father Christmas, giving toys to all the others, insisting on the curtains being drawn to make it dark and realistic. Another only adopted child in the group with fears of the dark revelled in being used in this way ; she became one of the big family and gradually came to fear the dark no longer.

As a group develops, having worked together for some time, the relationship between the children frequently goes further than merely using one another as objects for phantasy play. It may happen that a child finds another one whom he can use as a transference object, as he might use the therapist in individual treatment. An emotional tie grows up between them sometimes sufficiently strong to make the one feel that the group is not worth while without the other. The therapist then often needs to do little but just be there. Her being there is a safeguard to the children as is the analyst to the patient under analysis. Her presence means that it is safe to express emotions and feelings which would otherwise be too dangerous. She is trusted to guide the children through their most destructive moods without actual harm being done. The children in the group know that the therapist is a safeguard - one who will prevent their actual destruction of themselves or one another — but one who will understand such desires without reproof, without disapproval. It is

very rarely that even children who are a terror in their schools do any damage to others in a group, even though they have access to tools and make themselves swords to fight with. Similarly, if they have hose-piping and water they seldom intentionally wet the other children. It seems as if having the weapons of aggression gives them some responsibility and control over them.

As in individual treatment, the aim of the group is to provide an atmosphere in which the child is free to externalise and to set into perspective his previous experience and thus to digest it. The atmosphere is essentially one where he is allowed to express his desires, his phantasy thoughts and feelings, and they are all admitted, without disapproval being shown. This does not mean that the child is allowed to break up the clinic; actually it is surprising how few children want to do so. It does not mean that the child is allowed to do physical harm to the therapist or to the other children; but the desire to break up is admitted as something real. It is allowed symbolical expression, played out, talked out or both, according to the age of the child. As, for example, when a group of rebellious children show their revolt against authority by making a model or a drawing of the therapist and pelting it with clay or sand. This may be done with zest accompanied by an expressive running commentary without any actual antagonism.

In group work varying degrees of interpretation according to the skill of the therapist are given to the child as in individual treatment. He gets better because of this help from the therapist and the help he can gain from the other children. He is thus enabled to face the facts of his life instead of running away from them. This type of clinic play group then is a collection of individual children, ideally each concerned with their own immediate aims. The attitude to the other children may be either friendly or hostile, or negative; but even though friendly, the other children are

used chiefly as a means to serve the child's own individual ends. Such a group may consist of children of varying ages — from three to, say, fourteen, although usually children of nearer the same age are seen together and sometimes boys' and girls' groups may be run separately. The result may be very much the same as the situation in a family nursery. It is probable that it represents a similar situation to the reliving of emotional experience through the transference situation in individual child or adult analysis. In addition, however, to the child being able to understand his own emotional difficulties and clashes with the outside world, he at the same time has the opportunity of making up lost ground in his ability to co-operate with others which is an essential attribute of the normal mentally healthy child but one often foreign to the neurotic.

In so far as each and every individual child in a treatment group has to be allowed the same degree of freedom to express himself as he would have in individual treatment, it follows that such groups impose considerable strain on the therapist. Not only must she keep her individual contacts with all the children, but she must sometimes jealously protect one child's freedom from the impingements of another. She needs to have developed a confident technique in individual treatment, and also to have acquired a kindred skill to that of the nursery school teacher who has to allow a number of children freedom to express themselves in a group. The field is one in which there is room for new techniques to be worked out, and may in the future be the link between the strictly therapeutic work of the clinic and the earlier preventive work of the schools.

Chapter Twelve

Treatment (3)

ADJUSTING THE ENVIRONMENT

IT is characteristic of the neurotic patient that he suffers not only from a conflict within the personality, but also from a relative incapacity to cope with the external circumstances of his life, and to get on with other people. The difficulties in his environment which are contributing towards the neurosis may be real, or, on the other hand, they may be largely illusory or caused by the patient's neurotic behaviour In any event, in the course of treatment some modification of the environment is almost always necessary. One main difference between the treatment of an adult and that of a child is that in the former case the patient himself is expected to make the necessary adjustments, indeed the success of the treatment is largely measured by his progressive ability to do so, whereas in the latter case they must generally be made by others. Thus the adult patient may find it necessary to leave home, or to change his job, or take up a new hobby; and the change, side by side with the therapy he is receiving, contributes towards his cure. But if a child does not get on with his parents, not only is he obliged to put up with them, but he actually needs them, not only materially but, even more, emotionally. He has thus a much greater dependence on his environment, and at the same time almost no power to alter it. Even where what is necessary is merely a change of school or a camping holiday or a new outlet for his abilities, he can accomplish none of these things for himself; for however clear-sighted and resolute he may be, he can take no serious step to alter his environment without the backing of adult authority. In a child guidance clinic it is

the task of the social worker in co-operation with the parents and others to make all those necessary changes in the environment which the child cannot make for himself.

Since the parents are the most permanent and influential factors in a child's environment, it follows that the social worker is primarily concerned with them. First the ground must be prepared for that co-operation without which successful treatment of the child is impossible, except perhaps in the cases of some very intelligent children, or of adolescents who are reaching the stage when they may reasonably be expected to adjust themselves to their environment. Sometimes, where it has not been possible to arrange for a preliminary home visit, or the child has been referred by the court or school without the parents having been consulted beforehand, the latter arrive full of resentment or open antagonism, and take some time to be convinced that the clinic exists to help and not to censure or override them. They must then be made to see that acceptance of its full service is not only voluntary, but also implies active goodwill and effort on their part If, however, the social worker has already made a good contact in a preliminary home visit, the parent will be prepared to give a measure of co-operation which is sufficient to start with. She will at least undertake to bring the child regularly for treatment, and not to question him about what goes on in his sessions with the psychiatrist or play therapist, accepting it on faith that something useful is being done, obscure though it may appear.

The next step is for the social worker to give some explanation of the methods employed. Unless this is done early in the treatment, and even repeated from time to time, most parents begin to feel that they are wasting their time in bringing their children to a clinic where they apparently do nothing but play. The relation of play to phantasy life, and its use in diagnosis and treatment, are not easy matters to explain to those who are unaccustomed to such ideas. Fortunately it is usually only the more intelligent who demand

a theoretical exposition. In most cases a few telling examples are all that is required to indicate the psychological approach to what is normally regarded as entirely purposeless activity. It may be pointed out, for example, that a child who chooses to play with toys that are normally only appreciated by much younger children is showing that in some ways he is not as grown up as he ought to be. The therapist in allowing him to play with such toys is helping him to grow through the baby stage, so that he will no longer wish to return to it. The wish to remain a baby may be at the root of his trouble, which only appears on the surface as thumb-sucking or bed-wetting. Or, again, most parents will understand that 'pretending' games can throw light on a child's hidden wishes. They may be able to produce examples from their own childhood. One mother admitted that as a little girl she had often pretended to be a changeling, the daughter of a princess. "I suppose," she added, "that that was because I was dissatisfied with my home, though I never dared to tell anyone." It was then easy to point out that if she had gone to a child guidance clinic and had expressed her phantasy in play or drawing or writing it would have been understood, and she would have been encouraged to talk of her unhappy home life without fear, and something might have been done to improve matters, or at any rate the understanding that she found would have made her better able to cope with it.

In some such way the social worker must make sure that a measure of understanding is achieved, otherwise the parent may unconsciously undermine the treatment by disparaging remarks, such as that of the mother whose only comment when her small daughter emerged from her session gleefully declaring that she had made a mud pie was, "Well, the doctor *will* think you a baby, I'm sure." Even if she is in a position to do so, it is not however advisable for the social worker to give to a parent a detailed description or interpretation of her own child's play. To do so would in many

cases be as much a breach of confidence as to repeat the child's confidential statements; moreover it is apt to evoke either incredulity or resentment. It is enough if she uses the knowledge in her possession to give a general idea of the child's problem as seen in the light of psychological knowledge. This much the parent expects and has a right to. Thus in answer to a query "Well, what has the doctor discovered about Johnny?" it would be legitimate to say "He plays as though he were very jealous of his little brother Peter," but it would be unwise to add "He took a doll which represented Peter and drowned it in the bath."

Whenever possible the social worker sees the parent each week when the child is brought up for treatment. As was explained in a previous chapter, the child's problem often arises out of a wrong attitude on the part of the parent, who may be inducing a neurosis by behaving in a neurotic manner towards him. Obviously, something must be done to alter such an attitude if the treatment of the child is to be successful. This raises the question about which there has been some controversy even among psychiatric social workers themselves, of whether the social worker should undertake 'treatment' of parents. Cogent arguments can be put forward on both sides, but if certain fundamental principles are kept in mind, the solution seems fairly obvious. In the first place it should never be forgotten that a child guidance clinic exists for the treatment of children. In every instance, if a case is accepted at all, it is the child who is the patient, and any parent who consented to bring her child on this understanding only to find that she also was regarded as a patient, and was expected to undergo treatment, might be justifiably indignant. The child guidance worker is not concerned with the mental health of the parent *except* in so far as it directly affects the child. But provided the child's problem is made the starting-point and the limiting factor, there can and must be a certain amount of discussion of the parent's own problems, and this does not arouse resentment,

since its relevance is obvious. A parent who is found to be suffering from a serious neurotic condition which could not be alleviated without a thoroughgoing personal analysis should, however, be referred to an adult psychological clinic, where one is available, rather than undergo treatment in the child guidance clinic even with her explicit consent. Not only is this recommended because, as mentioned in the Introduction, it is inadvisable for parent and child to be patients at the same time and in the same place, but also because the practical difficulties in most child guidance clinics make such a procedure unworkable.

The principal argument against the treatment of severe neurosis being undertaken by the social worker rests, however, on the fact that she seldom has the necessary knowledge or experience, since the recognised training for psychiatric social workers is not intended to be a qualification for this type of work. But even where in individual instances the social worker has extra qualifications and is personally capable of undertaking the work, the conditions under which she must normally work are particularly unfavourable. By reason of the diversity of her functions she is always liable to be interrupted, her session with the parent must be terminated as soon as the child is ready to go home, and the child himself may be a source of distraction, bursting into the room to demand a handkerchief or some other attention, or merely to reassure himself that his mother is still there. Finally, attendance of the parent at the clinic ceases abruptly with that of the child. It would not normally be consonant with her other duties for the social worker to continue treatment of the parent long after the child were cured, and since the treatment of adults usually takes longer than that of children this would often necessitate breaking off the treatment at a most unpropitious stage. Most of the above arguments apply against any worker in a child guidance clinic undertaking the full treatment of neurotic parents; but they point especially to the fact that this should not be regarded

as a part of the social worker's duty.

On the other hand, to interpret the statement that social workers in a child guidance clinic should not undertake treatment as meaning that they should in their contacts with parents avoid bringing to light unconscious material, and confine themselves to dealing with problems on a superficial level and the giving of good advice, is surely to misunderstand the whole purpose of psychiatric as opposed to any other form of social work. Comparatively few of the parents who bring their children to a child guidance clinic are neurotic enough to require treatment on their own behalf. On the other hand, many are possessed of unconscious attitudes which are either causing, or contributing towards, their children's problems. Perhaps the most important of all the social worker's duties is to supplement the therapist's work with the child by helping the parents to change these attitudes. But obviously an unconscious attitude cannot be changed merely by giving good advice. It must first be made conscious, and its hidden motives revealed, and in doing this the social worker must make use of some of the same methods as the therapist. The following examples will perhaps make this clearer.

It became obvious during the treatment of a boy of fifteen for running away from school and irresponsible behaviour that his mother was being grossly over-protective towards him. Whenever the social worker pointed this out, however, the mother vehemently denied it, producing in her own defence many arguments which, not knowing the facts, the social worker was unable to refute. After several weeks, during which no progress was made, the mother suddenly said, " I have been having such funny dreams about John lately. Last night I dreamt that he had done something wrong and his father was chasing him round the table, meaning to punish him — then all at once he became a baby in my arms, and I had such a sense of relief to think that no one could touch him." With very little prompting this

woman was then able to see that her unconscious mind was telling her through the dream exactly what she had refused to accept from the social worker, namely that she wished to protect the boy from the consequences of his own actions by keeping him a baby. In this way she was able to accept an interpretation which she had rejected when it came from outside, and to recognise the necessity for a change if the boy were to grow up a responsible member of society.

Or to take another example, a girl was brought to the clinic suffering from apparently irrational fears of being poisoned. The mother was perhaps slightly neurotic, but there was no very obvious connection between her condition and that of the patient. She was friendly and co-operative, and in her weekly interviews she was encouraged to talk freely of any problem that came into her mind. After a few weeks she volunteered that at one time she had had uncontrollable sadistic impulses, particularly towards this child. " When Alice was about four years old," she said, " I don't know what came over me, but I was so mad with her one day that I held her hand against the bars of the grate and burned her really badly. Then I wouldn't even bind it up. It gave me a good fright though: I didn't know what I might do next." Since then, she said, she had not had any more cruel impulses, the fright had 'cured' her. Further discussion made it clear that the impulses still remained, but that owing to the shock she had had they were no longer allowed to come into consciousness. Nevertheless they were being gratified in a subtle way. Thus, whenever the girl expressed anxiety about anything the mother's method of reassuring her was such as to leave her with a suspicion that her fears were justified. For example, the child might ask, indicating her plate: " Mother are you sure there are no germs here? " to which she would receive the reply, " Don't be silly, there are germs everywhere but you're more likely to meet your death through worrying."

The connection between the mother's attitude and the

girl's fears now became clear, and it was necessary to point this out to the mother and see if anything could be done to change her attitude. In tracing back her sadistic impulses it was found that they had existed long before the birth of this child, in fact they dated back to her own childhood. Her father had been a drunken bully, her mother, to whom she was much attached, had played the part of a patient martyr. She had often as a child witnessed scenes in which her father had come in drunk and knocked her mother about, whilst she sat mute in a corner "boiling with inward rage", as she described it "and longing to kill him, but not daring to move". "I suppose," she volunteered, "that I'm venting all that rage on Alice now. It seems a shame really, but she annoys me, she is so helpless." Then she remembered that her mother's helplessness had annoyed her in the same way. So she came to realise that in her treatment of Alice she was unconsciously avenging herself upon her father, and at the same time punishing her mother for being so helpless and thus causing her as a child to suffer. No doubt a full analysis would have revealed much more, but with even this amount of understanding the tension was greatly eased, and she was able gradually to build up a more sympathetic attitude towards Alice. It so happened that the relevant facts in this situation were fairly readily accessible to consciousness. If they had not been, it might have become necessary to refer her elsewhere for a complete analysis if there were to be any hope of treating the girl successfully.

Methods such as those described do certainly constitute treatment; but it is treatment of a strictly limited kind, with attention focussed on the child's problem rather than on that of the parent. Nevertheless the latter often develops towards the social worker something of the attitude of a patient towards the therapist. In so far as this is merely a conscious attitude of respect and trust, it is a necessary basis for successful work. But sometimes the relationship is disturbed by an eruption of irrational elements from the unconscious,

and we have what is known as a transference. A transference is said to exist when the patient as a result of the activation of unconscious material transfers to the therapist feelings which he originally had towards others, usually the parents. This may lead to exaggerated feelings of love and dependence, or, on the other hand, to moods of apparently groundless suspicion and hostility towards the therapist. The social worker needs to exercise considerable skill and tact in dealing with the difficulties of relationship which may arise out of the transference situation, for if she is unsuccessful the child's treatment may be jeopardised. For this reason she cannot afford to take risks that would be allowable of she were treating the parent on her own account.

The necessity for recognising unconscious attitudes, handling difficult transference situations, and interpreting the material presented in phantasies and dreams, makes it highly desirable that the social worker should herself have been analysed, both as an education in technique and as an aid to the understanding of her own blind spots and prejudices. The psychological insight so gained is of almost equal value in those other aspects of her work which, whilst not concerned with individual therapy, offer abundant scope for analytical understanding.

The difficult task of changing parental attitudes need fortunately only be attempted in a minority of cases. There is much else to be done in the weekly interviews. For example, it is necessary to help parents to deal with such problems as may arise with their children during the course of treatment. Often a child changes considerably whilst attending the clinic, and the change does not always at first sight appear as an improvement. Thus it is not uncommon for a shy inhibited child to become cheeky or aggressive, or for a delinquent to regard his visits to the clinic as a mark of distinction, so that the anxious parent wonders what has gone wrong. " I hoped the doctor would give him a good talking to," many a mother remarks, " but he comes out as

pleased as Punch and asks when he can come again." Occasionally it even happens that the original symptoms are temporarily aggravated. In problems like these the parent needs reassurance and help in understanding the causes. . . . Then again, many parents become impatient if they see no immediate change, or if progress is slower than they had expected. It has to be pointed out that psychological, like medical, treatment takes time, and may even be painful and produce unpleasant symptoms of its own; but that these clear up in due course if the patient perseveres with the treatment. Parents often have to be persuaded to allow the clinic to carry its own burden, for at the back of their minds they have the feeling that it is up to them to cure the child, and they cannot quite trust anyone else with the task. There is, of course, an element of truth in this which the social worker will acknowledge in preparing the parent to re-assume full responsibility at the first possible moment.

In discussing these day-to-day problems it is as well to avoid giving too much direct advice. Some parents try to force the social worker into assuming a roll of infallibility, particularly if they are unwilling to make any real effort to deal with a situation themselves. If she falls into the trap she gives such a parent the opportunity of saying, after having made a half-hearted attempt to act upon the advice given: "Well, I tried what you suggested, and it didn't work, what am I to do now?" Any further advice given will of course be equally unsuccessful if it is carried out in the same spirit. On the other hand, there is a type of parent who will accept any advice with complete faith, and act upon it with scrupulous care, in the belief that the social worker, by virtue of her mysterious knowledge, is possessed of a magic key which will open all locks. In cases like this, almost any advice is likely to be successful, or at least to appear so to the parent; but it only serves to strengthen the latter's childish and dependent attitude. If by any chance it fails in its object, she is likely to be unduly disheartened,

and perhaps quite disillusioned with the clinic.

It is much better so far as possible to throw the responsibility back upon the parent by encouraging her to make her own interpretation of her child's behaviour at home, and her own suggestions as to treatment. In this way, independence and psychological understanding are developed, and, most important of all, the sense of failure and helplessness from which almost every parent suffers when she brings her child to the clinic is gradually replaced by a feeling of hope and self-confidence. Moreover, a method of procedure suggested by the parent herself is more likely to be carried out intelligently, to be consistent with her general attitude, and to appear natural to the child, than is an equally good or even better method suggested by somebody else.

It is often a help in developing understanding of a problem if the parent is encouraged to discuss parallel cases which have come within her own experience. Most people are quite willing to expatiate on the mistakes made by their neighbours, and in doing so they often show a considerable psychological acumen. It is usually not difficult to point out to a parent differences or similarities between the case she is discussing and that of her own child, and to convey criticism indirectly where it would not be advisable to do so more openly.

Since it is of paramount importance to build up the parent's self-confidence, anything that might be interpreted as hostile criticism must be used very sparingly, but it has its uses as a last resort. Occasionally a strong resistance is covered by an apparently amiable façade. Week after week goes by while the social worker tries in vain to get to grips with a problem and the parent resolutely guides the conversation into safer channels. One such mother would invariably reply when she was asked how her boy was getting on: "Oh, he's much the same, thanks," then go on, with apparent unconcern, to discuss the problems of her allotment. She kept her appointments with exemplary punc-

tuality, and seemed perfectly willing to go on attending indefinitely without expecting any improvement in the child. Any attempt to discuss personal matters was countered with a bland return to the vegetables. No progress was made until her complacency was shaken by having it pointed out to her that since she used the conversation to avoid telling things which she knew were relevant to the boy's problem, it looked as though she would rather not have him cured than risk any disturbance of her own peace of mind. In her indignation at this suggestion she revealed that she brought him to the clinic at great cost to herself, for ever since childhood she had been sick and terrified when travelling in buses. This was the starting-point of a discussion of her own carefully concealed neurosis, which soon proved to be intimately connected with that of the boy.

In the course of her discussions with parents, the social worker often comes upon the most curious superstitions, such as that a child's mental life is affected by the phases of the moon, or that he has been the victim of some malicious person who is gifted with the evil eye. More commonly it is believed that a mother's experiences during pregnancy exert a direct influence upon her unborn child. Thus a child's nervousness may be attributed to the fact that his mother witnessed an accident while she was carrying him, or his unwillingness to eat to the fact that she was unable to obtain the foods for which she craved. Whilst these and all other superstitions which tend towards a gloomy and fatalistic outlook, should be exposed so far as possible, it would be a mistake to treat them with contempt or regard them as personal stupidities. Some may even have a scientific basis which has yet to be revealed. At worst they are collective errors which have behind them the sanction of ancient tradition and widespread acceptance, and as such can only be eradicated by the patient substitution of more scientific explanations of the phenomena for which they profess to account.

When a parent is unable to attend the clinic regularly, and yet it is felt that intensive work is necessary, it is sometimes possible for the social worker to arrange a series of visits to the home. This, however, is only a last resort, for it has serious drawbacks. Such visits take up a great deal of time, and the fact that they involve much effort for the social worker and little for the parent does not mean that the latter appreciates them the more. On the contrary, there is a tendency to undervalue help which is obtained too easily. Moreover, when interviews are conducted in the home, the relationship between social worker and parent is subtly affected. The visitor is to some extent in the position of a guest, and the initiative thus passes to the parent, who is able to conduct the interview in her own way, which may not be therapeutically the best. She may, for example, allow interruptions by other members of the family, or break off at a crucial point to make a cup of tea, or give half her mind to the subject under discussion and the other half to the antics of the dog. Often, indeed, home conditions are such that with the best will in the world it is impossible to secure the necessary peace and quietness. Even in those cases (and they are many) in which no intensive work with the parents is being attempted, and the child attends the clinic alone, it is not advisable for the social worker to visit the home during the treatment if she can get the parent to come down to the clinic from time to time in order to maintain contact, and to report any new developments. In general, whilst a child is under treatment any interviewing which *can* be done in the clinic is better done there rather than in the home. Unfortunately, however, there are parents who neither answer letters nor keep appointments, and they of course have to be visited.

The social worker's time is not, however, wholly taken up with the parents, for she is concerned with every aspect of the child's environment. After the home, the next most important factor in the environment is usually the school.

It is often found that conditions there are in some way contributing to the child's problem, though this need not imply any criticism of the school. It may be that the child in question is reacting in an abnormal way to a system which is admirably adapted to the majority of normal children. On the other hand, teachers do occasionally make mistakes in difficult cases, for example in failing to assess a child's mental ability correctly, so that either too much or too little is expected of him. Often they are frankly puzzled by a child's behaviour, and anxious for advice as to the best way of dealing with it. In any such cases a visit to the school is indicated.

In some clinics school visits are undertaken by the educational psychologist rather than the social worker. There is much to be said for this practice, for the former is naturally better informed in such matters as the relation of intelligence to attainments, and the various methods of teaching and of school organisation, and is therefore in a better position to discuss problems from the angle that is of most interest to the teacher. The educational psychologist also has the advantage of having personally examined the child instead of having mainly to report the findings of other members of the staff. Admittedly, the social worker has much direct knowledge of the home background that may be of interest to the teacher; but this is not always an advantage, for information of this kind must often be withheld and always given with the greatest discretion if a breach of confidence is to be avoided.

However, in most clinics where there is a school problem, it falls to the lot of the social worker to call upon the head teacher and discuss with him the possibilities of adjustment. It is necessary to appreciate his difficulties in dealing with the abnormal child. Whereas the clinic is specially adapted to deal with such cases, the school is not. On the contrary, it is specially adapted to deal with normal children in a more or less uniform way. An exceptional child cannot be singled

out for special treatment without injustice to the rest, even if it only means that he is demanding a disproportionate amount of the teacher's time. The social worker, therefore, has no right, even if she has the desire, to suggest that the regime should be altered to fit a particular child. If, however, she contents herself with describing from a psychological point of view the relation between that regime and the child's problem, the head teacher will usually be found very ready himself to suggest adaptations which would meet the case.

Sometimes, however, it appears that nothing less than a change of school would be adequate. Unfortunately head teachers are slow to recognise that here again no criticism of the school is necessarily implied. It may be merely that the child would be better in a different type of school, for example in a technical rather than a grammar school. Or he may have acquired a bad name in his old school, or have got in with a gang who encourage each other in mischief, so that he feels he cannot make a new start without a change of environment. In such cases the good name of the school is not being queried, and it is certainly not likely to suffer if the change is permitted.

Sometimes when a child is referred to the clinic some other social worker is already in charge of the case, for example, if the child is on probation. In such a case it is advisable for the psychiatric social worker to make contact with the probation officer and arrange the work so as to avoid so far as possible any overlapping. Normally the probation officer would be seeing the child regularly at fairly frequent intervals, and visiting the home from time to time. If the child is to come up for regular treatment at the clinic, the probation officer would be advised to keep his interviews on a fairly superficial level, leaving the psychotherapist to deal with the child's emotional problems. On the other hand, unless there is need for very specialised intensive work with the parents, the social work on the case can be left

entirely to the probation officer, who will of course keep in close touch with the clinic. In this way perfect co-operation can be developed without parent or child becoming confused by too many advisers.

In the case of a child not on probation who has to appear in court after attending the clinic, it is sometimes asked if it would not be a good thing for the social worker to be present at the hearing of the case, so that she could give evidence concerning the home surroundings, and present a report from the clinic. Though such a procedure might sometimes prove helpful to the magistrates, it would be very undesirable from the point of view of the clinic for two reasons: first, because it would necessitate repeating in court in front of the parents information which had been obtained confidentially; secondly, because it would tend to encourage the erroneous belief that child guidance is primarily concerned with delinquency. This belief is already too prevalent and tends to diminish the usefulness of the clinics by making many parents shy about referring their children. But even from the point of view of the child in court, it is as well that the clinic staff should not be too visibly associated with the forces of law and order, to which he may have developed an aversion which it will take some time to eradicate. It is therefore best for child guidance workers to remain in the background, and to maintain contact with the courts by means of written reports for the magistrate to use as he thinks best.

The influence of the church may play an important part in the child's life. It occasionally happens through misunderstandings arising out of the different methods of approach that this influence appears to be in conflict with that of the child guidance clinic. This leads to extremely unfortunate consequences for the child. At best it means that he cannot accept the help offered by the clinic in full measure; at worst it may lead to a considerable increase in his anxiety, to trouble with the parents and perhaps to an abrupt termination of the treatment. Where there is any

suspicion of such difficulties arising it is as well for the social worker to make contact with the priest or minister concerned, and arrange if he so desires that he should visit the clinic and speak to the therapist himself. He will then realise that the child guidance clinic, far from wishing to set up as a rival authority to the church, welcomes any influence which is likely to help the child, and is prepared to co-operate so far as possible, for example, in encouraging the child to join a club or Scout troop attached to the church. Such discussions rarely fail to clear up all misunderstandings.

It often happens that in addition to such efforts as are described above, it is necessary to make some more positive demands upon the social services if the child is to receive the maximum benefit from his treatment at the clinic. It is then that the social worker's general training becomes indispensable, for she must know the resources of the community, and how best to make use of such specialist services as exist so as to avoid unnecessary duplication of effort, and preserve her own time so far as possible for the work that she is specially qualified to do.

It may be, for example, that the child is in such poor physical condition that a period of convalescence is necessary before he starts attending the clinic for treatment. The social worker will then refer him to a society such as the Invalid Children's Aid Association, which will make all the necessary arrangements. Or it may be necessary to secure extra clothes or bedding for a child. In one case a small boy referred for bed-wetting—" which always got worse in cold weather ", according to the mother — was found to be sleeping with nothing but a cotton sheet and an old coat for covering. There was not a single blanket in the house. In most districts there are voluntary organisations which will give assistance in cases like this, and it is a part of the social worker's duty to make use of them when necessary.

Similarly, when it is a question of placing a child in an institution or home, if the social worker has been successful

in developing contacts with other social agencies she will be able to count on them for assistance. There are such a large number of small homes and hostels run by different organisations, and differing widely both in the conditions under which they accept cases and in their methods of dealing with children, that it is practically impossible for the psychiatric social worker who only needs to make use of them occasionally, to select the most suitable one for a particular child without help. She is fortunate if she can secure the advice of someone who is in constant touch with such homes, as, for example, a diocesan children's worker.

The placing of children in foster homes is always difficult. This is largely done through the local education authorities; but in the case of problem children the results, if no special steps are taken, are apt to be unsatisfactory. There is however a Foster Homes Register which specialises in the finding of suitable homes for difficult children, run by the Provisional National Council for Mental Health. Many local authorities make use of their powers for the special placement of problem children needing treatment either by co-operating in this scheme, or in some other way.

Perhaps the voluntary organisations of which the social worker in a child guidance clinic makes greatest use are those specialising in recreational activities. Particularly in those cases where family relations are tense, or where the child is a bad mixer, or has developed anti-social trends, psychological treatment is accelerated if he can be given a new interest outside his home and the opportunity for companionship without the temptation to get into mischief. In large centres of population there is usually a fairly wide choice. He can join a Scout troop, or a club, or perhaps attend a play centre organised by the local education authority, to mention only a few of the possibilities. It is for the social worker to put him in touch with the organisation most appropriate to his individual need.

For the successful development of this side of her work it is obvious that the social worker needs not only a general knowledge of the scope and methods of numerous statutory and voluntary bodies, but also detailed information as to the resources of her particular district, including as wide as possible a personal acquaintance with those engaged in other forms of social work. Much remains to be done before the maximum co-operation between social workers can be achieved. There is still far too much ignorance as to what others are doing and too little trust in their methods. It ought, for example, to be possible for any qualified social worker to count on having her reports accepted and acted upon by other social agencies; but in fact most voluntary societies feel it necessary to send their own social workers to conduct the enquiries all over again before considering whether they can give the assistance asked for. This state of affairs not only leads to much duplication of effort and waste of resources, but is also apt to be a source of annoyance and confusion to the families in need of assistance. A child guidance clinic under the control of the local authority has this advantage, that it is then part of a vast network of services among which there is the minimum of such overlapping, but even so, such services can never cover more than a part of the necessary field.

We have considered the social worker's part in adjusting the environment as an adjunct to therapy. It remains to say something of what she can do to ensure that the work of the clinic is not wasted through backsliding.

In a certain number of cases when treatment is discontinued the case is not closed outright, but is handed over to the social worker for supervision. It may be that for some reason attendance at the clinic could not be continued until the child was completely cured, or that a relapse is feared, or the parents may be considered in need of periodic advice and encouragement. In such cases the social worker visits the home from time to time, and, if

the need arises, sees that the child is brought back to the clinic. In addition to such supervision work it is highly desirable both from the point of view of effective therapy and of research that every case should be followed up by at least one visit after a reasonable interval has elapsed since the termination of treatment. Where it is at all possible a series of such follow-up visits should be made, say one at the end of six months, and two more at intervals of a year. Only in this way can the permanent value of the work be ascertained.

Enough has been said to show that child guidance involves far more than the individual treatment of maladjusted children and that most of the remainder devolves upon the social worker. The range of her activities is so wide that she cannot afford to be a specialist, even though in large clinics where more than one social worker is employed some differentiation of function may be possible. What she loses, however, through the inevitable dispersion of her energy and interest is largely repaid by a corresponding breadth of vision, for she has unrivalled opportunities of observing the problems of the individual, the family and society in all their intricate relationships.

Chapter Thirteen

Treatment (4)

REMEDIAL TEACHING

A SMALL percentage of the cases seen at child guidance clinics are referred specifically for failure in school work. In a larger percentage failure in school work is an associated symptom, sometimes found to be a direct cause of the main symptom for which the child is referred. In such cases, for example, a child may be playing truant, running away from his failure, may be stealing as a compensation for it, or may develop a facial twitch expressing the anxiety it causes him.

Individual remedial teaching in the subject in which the child finds difficulty is one of the ways of helping him. This may either be provided in the school or in the child guidance clinic.

The provision of facilities for remedial teaching in the school has the advantage that there can be a close contact kept with the child's own class teacher and a greater knowledge of the method she is using with him. Also, there is not the same waste of school time in travelling to and from the clinic, which the backward child can ill afford, and the teaching can be given at more frequent intervals. On the other hand, there are a number of cases where a fundamental change in attitude is required before the child can begin to make progress. In these children, clinic treatment, at least at the beginning, is a great advantage. Under some authorities the work of the psychologist doing remedial teaching in the clinic and the teacher doing remedial teaching in the school are closely linked together, so that interchange of children and mutual advice is readily available.

Treatment (4)

It is inevitable that there should be a high positive correlation between a child's native degree of intelligence and his ability to absorb school teaching without undue strain. Some of the children referred for backwardness in school work are backward simply because their mental age is too far below the average mental age of the class for them to be able to keep up with the work. These are the children often with *I.Q.*'s below 85. They fall into the group for whom the provision of special classes or C streams is a necessity and for whom a comprehensive system of remedial teaching in the schools should be provided.

Backwardness in school work, however, is not exclusively the result of a low *I.Q.* It may be a direct result of the child's unsatisfactory character formation, which is making it impossible for him to co-operate readily in receiving teaching at school, or it may be a direct consequence of having missed long stretches of school when the groundwork of the subject should have been learnt. Further, inability to learn may be the direct result of an immediate difficulty in the child's home life which he is absorbed in solving in his phantasy. All his mental energies may be used in this task to the detriment of any outside claims. Long-standing neurotic conflict within the child may have a similar result by absorbing all the available energies in its solution. It follows that the origin of the difficulties must be tackled either before or at the same time as remedial teaching is given, for it to have any effect. Such difficulties, however, are not always expressed in a direct cause effect relationship, and may be neither understood by the child himself nor by the teacher. It is these cases that require the services of the child guidance clinic, certainly in diagnosis and possibly in treatment.

Some children may express a definite hate for a subject. They hate the subject and hate the teacher, or hate the subject because they hate the teacher, or *vice versa.* Once they have been left behind in it they feel defeated and want to revenge themselves in hate, and their work often becomes

apathetic and effortless. This hopelessness requires skill to eradicate, and may often need deeper psychological treatment before the remedial teaching can take effect.

Other children react to difficulty in a subject by simply withdrawing from it into their own phantasy life — they may go through all the gestures of making effort yet, in fact, be far away from the task in hand. Such children are running away from their difficulties in just as effective a way as the truant, and in a way which is less easy to detect and often more difficult to tackle.

There are children who, as a result of failing in particular subjects, compensate for this failure by added effort and success in others. They may compensate for failure in formal work by success in art or domestic science. On the other hand, others are content merely with their own phantasy successes, or compensate for failure by cheap attention-seeking behaviour. With these children the use of phantasy as a method of escape from failure has to be first exposed, and then relinquished by the child, before any real progress can be made. Nevertheless, it is of very limited value to be able to bring home to the child the connection between his phantasy life and his school failure, unless at the same time some constructive attack on his problems can be made. The child must recognise and attempt to correct his own difficulties, but is usually incapable of doing this unaided. The psychologist, if he has been able to make an accurate diagnosis of the cause of the disability, is in a position both to help in this and to show the child how he can help himself. His method in the actual teaching is at first to provide easy attractive material which is stimulating to effort and gives some easy initial successes. The relief that is given by the removal of too hard competition is the best way of enabling the child to regain his confidence. He is thus able to attack the task in hand with energy and success. The initial facing of the difficulty is an essential before successful progress can be made.

This careful diagnosis of causes behind difficulties in school work, which is essential if treatment is to be carried out to the best advantage, has to be carried out with full information about the child. It is usual to find that the causation is not just simple but that there are many interrelating causes. Each case should therefore be investigated in the hope of isolating as many contributory causes as possible at the beginning, remembering that such diagnosis will probably become fuller as the remedial treatment proceeds.

The first step in diagnosis is to describe the actual difficulties. For example, in reading, a measure of the child's actual reading level as compared to other children is taken. The degree to which he falls below the normal of his age is then known. An analysis is then made of his particular reading difficulties and his most frequent type of error. The child's attitude to his failure is noted, how far he apparently minds it or disregards it, and whether or not it is colouring the rest of his life. Knowledge of the history of the difficulty will often give a clue to its origin and should be recorded when known.

The causes fall into different categories. First, they may have as their root some physical disability, such as visual or auditory defect, difficulties in motor control or general ill-health. Visual defects often cause reversals in letters or numbers, omissions and repetitions, and may be responsible for a very slow rate of work. Auditory defects often show themselves in reading through confusion of words that are nearly alike in sound, inaccurate speech, and inattention to any directions. Partial defects in both vision and hearing often escape detection until the child has been suffering from their effects on school work for a considerable time. A suggestion that a child has some deafness may be hotly denied by both parents and child; but if the type of school difficulty suggests that this is a contributory cause, such denials need to be verified by an audiometer test.

There are certain signs in general attitude to school work that may be suggestive of physical debility; for example, inability to concentrate, effortless behaviour, sleepiness and irritability or excessive fidgeting. Often the debility may only be a part of a multiple causation, or it may itself be a symptom for which psychological causes can be found.

Secondly, the causative factor may be a lack of mental capacity. The child with less than the average degree of general intelligence is hampered in progress in school work which is essentially designed in standard for the normal. Often such disability may be clearly recognised by the child who is continually consciously straining to keep up, whereas it is ignored by his parents and teachers. In these cases admission of the subnormality by the adults is a relief which serves to remove the child's guilt about his failure.

Thirdly, the root of the difficulty may be an emotional one, either in itself causative of the difficulty or resulting from it and itself becoming causative. A child may be emotionally immature, not wanting to grow up, enjoying infantile dependence and feeling that to succeed in school work would be a threat to his infant status. Or emotional immaturity may take the form of excessive timidity, the child being too shy to attempt any group work. A not uncommon emotional attitude is one of scorn for the school and school work caused directly by hearing parents speak disparagingly of it or of the teachers. The child's rejection of school is thus an emotional identification with the parent.

Emotional attitudes contrary to progress may be developed as the result of punishment for bad work, the work becomes associated with fear of punishment or fear of the teacher, and, as a result, a generally negative attitude may be developed.

Other causative factors may be found in the environment, either in the educational environment that has been provided at school, or in the environmental influences of the home. The school may not have provided sufficiently easy material

in the beginning and may have failed to recognise difficulties in their early stages. There may have been a lack of interest and enthusiasm on the part of the teacher, or the classroom conditions may have been too unfavourable to make learning an easy task. In the child's home there may be an atmosphere conducive to learning, setting in a high position the fruits of learning — or there may be one of illiteracy that sets learning as unimportant — similarly the home may give a peaceful secure atmosphere causing the minimum of strain in the child, or it may be one of strife resulting in antagonisms or anxiety.

It is obvious that some of the above causes of backwardness can be dealt with while others cannot; a recognition of the causes will go some way towards indicating the course of action that should be adopted, and in many of the cases some causes will be removable, leaving others to be accepted and contended with. For example, a low *I.Q.* cannot be raised, but defective vision may be corrected by glasses and emotional immaturity helped by psychological treatment.

Where a course of remedial teaching is undertaken this can either be done individually or in groups, but where it is done in groups each child must be considered as an individual with his own standard of achievement unrelated to the others. In the child guidance clinic remedial teaching is usually undertaken individually.

It is not in place here to discuss details of method to be adopted in each subject. These will vary according to the standard required and difficulty of the child in question, but in all remedial teaching the dangers of pushing the child beyond his possible level at the time must be kept in mind. To overpress is destruction to the end in view, the enabling of the child to take his own place among normal children of his own level.

One of the difficulties of teachers carrying out remedial teaching in the schools is that while being familiar with the general techniques of teaching, they are often inadequately

equipped or unprepared to deal with individual difficulties of individual children. The opposite difficulty is often experienced by the psychologist in the clinic who is familiar with dealing with the child's individual difficulties but does not possess a completely thorough knowledge of teaching techniques. The recognition of these limitations and a closer liaison between schools and clinics would make the service of remedial teaching more effective and valuable.

Chapter Fourteen

Social Implications and Future Trends in Child Guidance Work

THIS book has been concerned with the diagnosis and treatment of the difficulties of the child who is maladjusted. It has been shown how these difficulties may be expressed as specific symptoms. The section on causes of maladjustment has given a picture of the meaning of the child's world to him, and has indicated how his responses may be inadequate to the demands made of him, either because of some inherent abnormality or difficulty within himself, or because of some difficulty inherent in the environment. Further evidence has been given in this section to show that disturbance manifesting itself in a symptom of maladjustment may have very much earlier origins than the time of its first appearance. The symptom develops after the accumulated tension in the child has become too great, the situation has become too hard to bear. The symptom is a form of relief to the child, although at the same time it may ostracise him from the society in which he is living. Formerly it was common practice to attack the symptom, taking little account of the causation behind it. This proved to be both unproductive and unavailing.

Yet when such a symptom is one which is patently anti-social as is delinquent behaviour, the first essential from the point of view of society is that this should discontinue. Thus, for example, courts dealing with juvenile offenders have, as their first task, the prevention of further crimes. With this end in view the more enlightened members of the juvenile bench refer some apparently neurotic children to child guidance clinics, realising that the symptom cannot be satisfactorily disposed of without the cause being investigated

and adequate treatment either of the child or his environment being prescribed. The symptom thus comes to have social significance not only in its nuisance value but also as a signal to the grown-ups concerned that all is not well with the child. Members of the juvenile panel, in referring children for detailed psychological investigations, are concerned not only to prevent further delinquency, but also to ensure that the child in difficulties should be treated as reasonably and humanely as possible. A similar idea was behind the voluntary efforts of the enlightened citizens who started the child guidance movement in Britain to deal with the needs of difficult children whether the children were delinquent or not.

The principles underlying this movement are now generally accepted. Some standardisation in method has been achieved. The results in the improved adjustment of children after treatment can, within limits, be predicted, and child guidance as a social service has received recognition. In its approach to the child it is essentially clinical and individual; but its existence as a social service indicates that the child is being considered, both in his past and in his future, essentially as a member of the social group of which he is a part.

There is a shifting of responsibility for a child's behaviour from him to the society in which he is living. The child has come to be viewed as a product of his heredity and the accumulated effects of the environment in which he has lived; that he may inherit a degree of intelligence less than what is required for adjustment in normal society is now admitted. Such a lack comes in the same category as a physical disability, and legislation exists for protecting the child from the results of any consequent behaviour. Furthermore, as has been shown in Chapter Five, it is realised that no useful purpose can be served by throwing recriminations on the parents even though the cause of the difficulty can be directly ascribed to them. They

too are the product of their heredity and the family background in which they were brought up, and the harm they have done the child is seldom a direct conscious damage, but rather neglect from lack of knowledge, or from their own unstable character formation, over which at this stage they may have little power of control.

It has been clearly shown that neglect of individual needs causes difficulties in adjustment and development of symptoms which later demand time and energy to eradicate. In fact, child guidance method is often criticised for its extravagance in expert time. Readers of this book may have felt this criticism; certainly members of child guidance personnel often feel that their method is cumbersome. A great deal of effort may be expended to achieve changes in the attitudes and situation of a very few children who often at the best may only develop into C3 adults.

In the consideration of the future trends in child guidance, first, a simplification of method and economy of effort is of primary importance in order that the field of the work may be widened. Secondly, there is an urgent need for preventive work. Thirdly, comprehensive research should be planned.

Simplification of method has already been adopted by some authorities by a careful selection of the children being made before they are actually accepted for full clinical diagnosis. This may be done by the employment of psychologists who spend a proportion of their time in the schools where they see cases referred by the head teachers. These children are given the individual test in the school, if a suitable room is available, and if any neurotic signs are observed the child is passed on to the child guidance clinic. If, however, the child's difficulty in the school is primarily caused by a lack of intelligence or by a defeatist attitude to one particular subject, or by an obvious maladjustment caused by the school environment, the psychologist may be able to deal with the case by giving his diagnosis to the

head teacher and possibly by discussing the child's difficulties with his class teacher, or making some arrangement for remedial teaching.

Similarly, individual members of the clinic staff may be employed to follow up cases of pre-school children referred either directly by the parent or through the maternity and child welfare clinics. In these cases a visit to the child's home and discussion with the parents may be enough to alleviate the difficulty, or to give the parent the necessary confidence to deal with it herself. Useful work of this nature is being done now by psychologists and psychiatric social workers employed by the Ministry of Health to follow up cases of difficult evacuees.

It follows that psychologists and psychiatric social workers must have had sufficient experience in routine clinic work to recognise conditions which require to be referred for full clinic diagnosis. Further, both should have the facilities for calling in the other if they feel the need, and both should use the services of the clinic psychiatrist in cases in which there is any doubt about the diagnosis, and for all cases where clinic treatment is to be recommended.

In a simplification of work along these lines close co-operation between members of the team still remains essential and the services of all three types of worker need to be available. Such simplification is, in fact, a very considerable saving in clinic time in that it prevents the referral of cases for which the clinic can do nothing, and is, in fact, often the means of cases being referred at an earlier stage.

At present similar criticism is levelled at child guidance as is still equally applicable to a great deal of medical treatment, that is, that it waits until the diseased condition is obvious and developed before it treats it. To-day the school medical service is working primarily to prevent physical disease in order that it may not have it to cure. This preventive service has grown up as a direct outcome of the study and treatment of disease. A preventive service is now

due to grow up to safeguard the mental health of the child. In the same way this should be based on the detailed work of the analytic schools and child guidance personnel, who from treatment work of mentally ill children, have built up a body of knowledge, indicating the lines on which such preventive work will be based. Such knowledge should make possible the prevention of neurosis in the same way as the knowledge obtained from the work of the hospitals and school clinics in medicine has led to the preventive measures being taken to safeguard the physical health of the school child. School buildings are now designed to give fresh air and warmth, physical training is given to encourage healthy physical development, and there is regular school medical inspection. It cannot yet be said, however, that there is a similar application of psychology for the safeguarding of the child's mental health and emotional development. This may partly be because the mental health movement is at a much younger stage than the physical health movement, therefore the findings are not on such a firm basis. Physical standards are in general agreed upon; what is wanted is known; whereas psychological standards are yet partly unknown and largely unformulated, the knowledge that exists being still in the possession of only a few specialists.

The justification for pressing for a preventive service in the psychological field is the assumption, first, that there is a vastly greater number of children who would benefit from some treatment akin to child guidance than is able to have it in our child guidance clinics. Secondly, as all child guidance workers would agree, many of the children that are seen could, with benefit, have been treated at a much earlier stage, and on examination it is found that in fact their difficulties have been obvious at an earlier stage, though possibly they may not have been of a sufficiently anti-social degree to have made the adults concerned feel it a necessity to do something about them. Similarly, detailed case-histories of adult

neurotics show the early origin and often early development of symptoms indicative of a neurotic constitution which could have been more profitably dealt with in the early stages. The magnitude of the need for preventive work is such that the mere multiplication of child guidance clinics would be an inadequate method of dealing with it. Child guidance clinics will remain a necessity for advanced cases and should remain as centres for teaching and research. The early diagnostic and preventive work will come to be done in schools and in the home.

Through education teachers and parents will become more alert in observing the early signs of maladjustment. While it is a truism in psychological circles to say that early emotional development determines later emotional development, that childish love is a pattern for all later love relationships, it is not yet universally realised that the ability to love has to be learnt and practised like any other human faculty. Teachers and parents often show little concern when they have a child going through childhood apparently without this ability to show love. It may even be true that the conditions in many schools and homes to-day tend to foster and nourish an emotional detachment at an early age, rather than to encourage the expression of feeling, and the realisation of the reality of emotion.

It is sometimes argued that it is not part of the school's task to cater for emotional development, that this is the field of the parent in the home. In this respect, especially under war conditions, the child to-day may fall between two stools. The parents are so often working longer than school hours and on returning are too tired to listen to the child's chatter or to care for its emotional needs; and, again, they may even argue consciously that the child is being brought up at school, and that difficulties of his life when brought home should rightly be returned to school. If under such circumstances the child becomes sufficiently disturbed to show overt neurotic symptoms, meaningless stealing, lying,

playing truant, bed-wetting, stammering, bodily tics, at the best he may from the school be referred to a child guidance clinic. If then, after investigation, possibly after some waiting period, his case is thought suitable for treatment and if there are facilities to enable him to have such treatment, he may attend regularly for play therapy and usually his symptom clears up.

The question which might profitably be asked here is how far could the child's difficulty have been alleviated at an earlier stage, before the symptom formation occurred, had the adults concerned been more conscious? Often there is a time-lag of several years from the first appearance of the symptom until the parents and school are sufficiently disturbed to refer the child to the clinic. This is often increased if the symptom has no nuisance value.

Through play a child's symptoms can clear up and his adjustment be substantially improved. Enough has been said in Chapters Nine and Eleven to show that the separate factors in treatment concerned with such improvement have not yet been isolated. At present different workers may treat children in different ways, yet may achieve apparently similar improvement. It seems that the underlying common factor of all treatment is the freedom of expression which is given to the child. If such freedom of expression apart from interpretative treatment is of therapeutic value, might it not be possible to do preventive work along these lines in the schools? The question is how far existing teachers with some additional training could substantially treat children in the schools? Training colleges are now considering how teachers' training may be made less rigid and give students more understanding of the subtleties of psychological adjustment. There are, too, a growing number of teachers who are willing and anxious to learn more of the findings of applied psychology.

In the educational field to-day real preventive work is being done in the nursery schools, and gradually the nursery

school methods are being introduced into the older groups of children in infant schools. Children are allowed free play periods where their play material is in open cupboards and on shelves, and all the toys are common as in a nursery, and as in the playroom of a child guidance clinic. They are free to use them as they want and for the purpose for which they want. They have such a period of free play each day. Teachers doing this type of work are in agreement that though physically tiring to the teachers, it is in fact emotionally refreshing, and that the free play periods go easily and are full of a vitality of their own because each child is working on his own initiative instead of relying all the time on the ideas of the teacher. The keen intuitive teacher always makes an effort in some way to treat and improve his problem children. This effort, particularly when successful, is probably of therapeutic value to him in the same way as analytic treatment is of therapeutic value to the analyst. The handing over of children in the early stages of difficulty to an expert may therefore represent a net loss, in that it takes away from the teacher responsibility which is itself enriching. There may in this way be a danger in too much specialisation.

In order that such preventive treatment may be carried out to the best advantage, more training, more real knowledge, must be available to the teacher, and the advice of a specialist must be at his disposal. That such advice can be beneficially used was very clearly shown in a case of a difficult child in a residential war nursery. This child for six months had destroyed the peace of the nursery by having tempertantrums at her slightest whim. The child had been " badly blitzed ", and the teacher was at a loss to know how she could deal with such behaviour. It was necessary for the child to stay at the nursery as the home situation was impossible. On examination, the psychologist found that there were no signs of neurosis, and that the child was of high intelligence and was perfectly conscious of the weapon she

was using. She wanted the attention that she had always had in great quantities at home, and she was determined to get it: but she also needed more security. She was not afraid and showed no signs of having been directly affected by her experiences in the bombing. This information was given to the teacher and a course of firmer discipline, treating her as a normal member of the group in all respects, was decided upon. The child was left for a further month's trial on the condition that if there was no improvement a place in some special hostel should be found for her. At the end of the month the teacher had become so interested in the effect of the new treatment, and the child such a reformed character, that on no account would she think of parting with her. Not only the child but the teacher had gained by her success, and, further, she was concerned with minor, less anti-social, symptoms in two other of her children whom she was determined to understand and, if possible, treat successfully. This teacher had no exceptional insight, but was one with a good nursery school tradition, keen on her job, and prepared to learn.

Similarly, in classes now organised in schools for backward children much therapeutic work is done by the teachers. Sometimes they have a miniature house in a corner of the classroom where any children finding particular difficulty are allowed to hide themselves and play it out, and the children discuss their difficulties with good teachers with a very considerable degree of freedom. The play here, though not labelled therapeutic, is in fact largely therapeutic in aim in much the same way as is the play in a child guidance clinic. The difference is one of degree. The aim of play in the child guidance clinic is essentially curative, that in the school being in general preventive and creative.

The scope of treatment of children in school must of necessity be limited to the treatment of the child. As a rule the school is not able to modify the environment, as the child guidance clinic is, and is not able to give parallel

treatment of the parent. Further, it is not possible to create quite the same atmosphere of freedom. In the clinic the aim is to provide an atmosphere in which, and a therapist to whom, the child is free to express his difficulties. He is able to repeat and work through his previous experiences, and by facing them is able to externalise and digest them. The atmosphere is essentially one where everything is allowed to be expressed and all experiences are admitted as simple facts and disapproval is never shown. Antagonisms are allowed expression, are played out, talked out, or both, according to the age of the child. The clinic therapist gives varying degrees of interpretation according to the child's needs as she sees them. The children get better because with the therapist's help they are able to face facts instead of running away from them. There are varying methods of treatment necessary according to the depth of the complaint. Similarly, there are varying degrees of cure. How much of the cure depends on the interpretations given, the atmosphere provided in the clinic, the modification of the child's environment through the attitude of the parents varies in different cases. There is of course no doubt that in severe cases of estrangement from the demands of the real world, manifested in neurotic symptoms, skilled therapy is demanded. But these severe symptoms mostly start at a much earlier date in a much milder form, yet in a form which can be seen by the observant teacher. For example, the child who is apart in the nursery and infant school, or over-attention seeking, or late to develop habits of cleanliness, or inarticulate in speech, or inhibited and tight in movement; the child who bites his nails and twitches, or who is cruel and aggressive to others, is one who has temporarily got out of step in his development and who has probably lost confidence. To what extent would it be possible to give extra provision in school so that such children are able to develop to their utmost, and avoid the consequence in later life of effortlessness, which is, so often, effort turned 'within' on

useless unproductive conflict rather than turned 'without' in creative behaviour ?

It is obvious that the school atmosphere in general cannot be one where 'everything is allowed'. That would be a contradiction in terms. The school essentially must help the child to control, to modify his behaviour, and equally obviously the teacher must show disapproval of certain behaviour. She cannot behave as the therapist does in the clinic. But is it possible that with greater knowledge in addition to her function as teacher she could provide some facilities for children to externalise their difficulties in play or in words ? Could she by wise choice find children who would almost treat one another as they do in groups in child guidance clinics ? Here they cure one another because they express themselves to one another, but this is in the clinic atmosphere. Would it be possible for some part of school in some times of the school day to achieve this same atmosphere ? The study of drawings of school children show that there is in many of the schools a very marked freedom of expression allowed and encouraged. Free drawing gives children the possibility of free expression of their difficulties. If this expression is overt not only to themselves in their pictures, but also to the teacher to whom they describe the picture, the value of the experience is multiplied, but this demands tolerant and comprehensive understanding from the teacher.

As a result of the urgent needs of the children coming to clinics, up to the present research has been pushed out. The position now is that there are a great number of clinic records which provide detailed data on all sides of the child's development, but very little has been done to co-ordinate this data and to compare it with similar material obtained from control groups of normal children. Inevitably clinic records only refer to a minutely small and selected percentage of the population. It may be evident for example in these, that a factor such as illegitimacy, a broken home, being

a foster child has been a significant and important cause in the child's maladjustment. Research planned to investigate samples of mentally healthy, normally developing children who also have these factors in their lives is needed before generalisations can be made on their effects.

Such investigations with scientific isolation of factors in adequate-sized control groups, would give more than simple information on the relative importance of different factors in maladjustment. They would also give empirical information of a more positive nature on what factors are needed to enable children to deal successfully with irregularities in their family structure. They would show how far such children are dependent on the attitudes of those around them, and the effects of honesty of approach to their problems. There would thus be provided a body of knowledge built up from the study of children who had successfully surmounted their difficulties, which would give valuable help to clinic workers, and others whose work it is to give advice on the upbringing of problem children.

It may be said in conclusion that the social implications and future trends in child guidance work point to a greater study of both mentally healthy and unhealthy children and the conditions under which they develop, so that a greater body of knowledge can be built up. For this purpose through the study of the mentally ill the child guidance movement with its fully qualified and trained staff is admirably suitable. There are signs that parallel to this there is a psychological service growing up for the study and benefit of the normal child in family and school. The aim of this is to safeguard the development of each individual child, and to insure conditions which will encourage the development of creative effort in each child to its limits.

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THE END

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